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Multiple Bilateral Rib fractures associated with severe coughing : **JK-Practitioner 2005; 12 (4) 199 to 200.** Please read last author of the above article as **Naveed Nazir Shah** instead of Naveed.

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surface TF. Among thrombogenic factors, the expression of tissue factor and of cancer procoagulant by tumor cells plays a major role. TF is a physiological initiator of blood coagulation through its cofactor activation of factor VII. Evidence of active coagulation such as presence of fibrinopeptide A level are found in over 75% of patients studied[20].

As a result an adequate fibrinolytic response is required to prevent thrombosis. Thus the level of fibrinolytic inhibitors found in the cancer patient may be of utmost importance in determining the occurrence of this complication.

Among cancer patients a number of risk factors have been identified that predispose to VTE as listed in Table 1. The anti-cancer drugs associated with increased risk of VTE are numerous and are listed in Table 2. Cancer patients are prone to VTE because of chemotherapy . Two mechanisms have been postulated and accepted for chemotherapy associated thrombogenesis : a) release of procoagulants and cytokines as a result of toxic effects on damaged endothelial cells and b) a fall in naturally occurring anticoagulants, such as protein C, protein S and anti-thrombin III, during therapy. Tamoxifen heightens the risk above that of a standard chemotherapy regimen in both premenopausal and postmenopausal breast cancer patients[21]. Similarly patients with advanced gastrointestinal , pancreatic and gynaecological malignancies are thought to have an increased risk of thrombosis and a study in patients with ovarian malignancy demonstrated a thrombosis rate of 17% , among those operated on and receiving chemotherapy[22].

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Table 1. Risk factors for VTE

1.Advancing age
2.Inactivity and immobility
3.Prior episode if VTE
4.Myocardial infarction
5.Hormone replacement
6.Paralysis
7.Surgery
8.Chemotherapeutic agents
9.Narcotics
10.Increased viscosity
11.Polycythemia
12.Macroglobulinemia
13.Dehydration
14.Infectious agents
15.Radiation therapy

Table 2. Anti-cancer drugs predisposing to VTE

1.Tamoxifen and SERMs
2.Thalidomide
3.Bevacizumab
4.L-Asparaginase
5.Doxorubicin
6.Irinotecan
7.Cisplatin
8.Diethylstilbesterol

Clinical manifestations

The incidence of symptoms or signs that may alert a clinician or oncologist to the diagnosis of DVT includes (23) :

1. Calf or leg swelling (88%)
2. Pain (56%)
3. Tenderness (55%)
4. Warmth (42%)
5. Erythema (34%)
6. Homan s sign (13%)
7. Palpable cord (6%)

Alternatively a DVT may remain asymptomatic and be diagnosed only when a patient develops pulmonary embolism features, which ae as follows :

1. Dyspnoea(77%)
2. Tachypnoea (70%)
3. Chest pain(55%)
4. Tachycardia (43%)
5. Hypoxia/Cyanosis (18%)
6. Hemoptysis(13%)
7. Hypotension (10%)
8. Syncope (10%)
9. Sudden death

Long term morbidity caused by DVT is Post-thrombotic syndrome (PTS) that develops in upto 80% of involved extremities within 6 years after initial treatment of DVT with heparin alone. PTS is characterized by a galaxy of symptoms[24]:

1. Pain or muscle fatigue with ambulation
2. Varicosities
3. Hyperpigmentation of skin
4. Subcutaneous fibrosis
5. Venous stasis associated skin ulcers

The first diagnostic test performed when the physician first suspects DVT is the ultrasound of the involved extremity because of its general availability, non invasive nature, and sensitivity and specificity. The gold standard is contrast venography which detects an intraluminal filling defect. Impedance Plethysmography is another method to evaluate the presence of DVT, often in combination with ultrasonography. Compression ultrasound with venous imaging is the most commonly used diagnostic test. There is an increasing interest in magnetic resonance venography.

Thromboprophylaxis

In cancer patients thromboprophylaxis is indicated in three clinical situations : (a) Peri-operative thromboprophylaxis, (b) Thromboprophylaxis during chemotherapy and (c) Prevention of catheter thrombosis. Safe and effective pharmacologic agents are readily available for the prevention of VTE in high risk patients. Recent trials indicate that low-molecular-weight-heparin (LMWH) may be very useful in selected patients[25]. LMWH have much greater bioavailability and a longer half life than unfractionated heparin when given subcutaneously. They are associated with much less frequent osteoporosis and thrombocytopenia[26]. Several prospective trials report a lower rate of VTE events when using LMWH in combination with external pneumatic calf compression[27,28]. DVT prophylaxis in cancer patients with high risk factors requires graduated pneumatic compression stockings plus LMWH, adjusted dose heparin, and oral anticoagulation with warfarin to achieve an INR goal of 2 to 3 (29).

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Prevalence of Post-Traumatic Stress Disorder in Kashmir

Mushtaq A Margoob, Aasim Rashid Parray, Tasneem Nehra

Primary Care Companion to The Journal of Clinical Psychiatry 2008; 10[4]: 67 In Press

Table-1: Total number of Patients (N) =16
Male = 08; Female = 08

S.No.	Type of Amputation	No. of Patients (N)	Part amputation	Reason for amputation
1.	Therapeutic surgical Amputation	06	L forearm 1 Below knee 3 Above knee 2	Osteosarcoma 3 Gangrene 1 Neglected CTEV2
2.	Traumatic Amputation	10	R arm 2 Below knee 5 Above knee 2	RTA 4 Blast trauma 2 Firearm 2 Earthquake 2

Discussion

The results of this small study reveal that traumatic amputations following accidental injuries or violence leads to an alarmingly higher (80%) rates of PTSD. These results are consistent with findings of studies conducted by researchers in the west[12,15,21]. The reason for such high prevalence of PTSD in these cases could be related to amputation itself, the accident leading to injury or the combination of the two factors. In addition it could be that for those losing limb to such events, the pain, the disability, and the psychological adjustment required, exacerbates existing post traumatic stress by way of constant physical reminders of trauma and added complexities of daily living. Another reason could be that amputation heightens the perceived threat to life embodied by the accident and thus contribute to PTSD symptoms[22,23]. In addition multiple exposures to traumatic events is known to be a grave risk factor to develop PTSD[24,25,26].

In view of chronic conflict situation prevailing here in Kashmir, majority (58.69%) of people (males = 59.51%, females = 57.39%), , as revealed by one of the first such studies from an Asian region by Margoob and his associates, have experienced a lifetime prevalence of traumatic events with firing and explosions being the commonest traumatic events encountered (81.37%)[27].

Another reason for high prevalence of PTSD among our study group could also be due to very poor or nonexistent systematic post amputation rehabilitation programmes which hampers coping and recovery after such tragedies.

The results of our study regarding emotional reactions to the experience of amputation also revealed that PTSD did not develop in majority of those cases who had undergone therapeutic met criteria for PTSD. These findings are supported by study conducted by Cavanagh et.al[6]. The reason for this could be that these patients met the experience with acceptance and optimism for future; as most of the patients had undergone planned amputations necessitated by complications of chronic illness and were prepared for the procedures and its consequences weeks to months ahead. Still the development of PTSD in surgical amputations could e due to learning of the need for amputation, the anxiety of preparing for the surgery, or awakening after the surgery to confront the actual loss of the body part, they would not have consciously experienced the event that would generally be considered most traumatic (i.e amputation).

The findings of our study therefore are consistent with the models of PTSD suggesting that the more uncontrollable and unpredictable the traumatic event, the more likely it is to lead to PTSD[15].

Small sample size was a limiting factor in our study. So this sparse data in our study suggests that extensive study of psychiatric morbidity in this population is warranted and clinicians traumatic amputation. Further research should aim at evaluating a larger group of participants (both therapeutic and accidental/violence related amputations), with a detailed, preferably longitudinal, assessment of a wide variety of socio demographic and other pertinent factors like functional limitations involved, time since injury, nature and extent of social support network and previous experience with loses[28].

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Chamydia Trachomatis Infections in Female Reproductive Tract in Patients Enrolled at Srinagar, Kashmir, (India)

Wazahat Hussain; Manzoor Ahmad Thokar; Tahir Malik; B.A Fomda; Gulnaz Bashir, Assadullah Sheikh

Abstract

Genital tract infections with Chlamydia trachomatis are a major cause of pelvic inflammatory disease (PID), ectopic pregnancy and infertility among women. This study was designed to document the prevalence of Chlamydia trachomatis infections in female genital tract in Kashmir Valley, first of its kind in this region. The study included specimens from 120 randomly selected women attending the Gynaecology OPD of SKIMS Medical College Srinagar over a period of two years. These women presented with complaints suggestive of mucopurulent cervicitis, PID and vaginitis. Endocervical specimens from these women were collected and processed using Direct Flourescent Antibody Test (DFA) & Enzyme Immunoassay (EIA). Out of 120 patients studied for Chamydia trachomatis antigen carriage from endorcervical specimens, 15% tested positive by Direct Flourescent Antibody Test. EIA when used simultaneously was found to be quite sensitive and specific. Result of this study suggests that Chlamydia trachomatis testing should be included in routine obstetrics and gynaecology practice in this part of the country. Although culture is the gold standard for diagnosing Chlamydia trachomatis infections, DFA being highly specific and sensitive can be used where culture facilities are not available, EIA being quite sensitive and specific can be used in setups where large numbers of specimens are to be processed.

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Introduction

Chlamydia trachomatis is the most common bacterial sexually transmitted infection and women carry the main burden of this disease[1]. If left undetected and untreated, chalmydia can ascend the upper genital tract, causing inflammation and scarring in both female and male reproductive tract[2]. Many reports now indicate that it is the major causative agent in the development of pelvic inflammatory disease (PID) in women. The major sequel of PID include ectopic pregnancy, infertility and chronic pelvic pain. Hence, screening of Chlamydia trachomatis in female reproductive tract can assist in designing strategies to reduce the prevalence of this infection. Culture is the gold standard but is expensive, time consuming and technically difficult. Since the early 1980's new technologies have been developed for the detection of Chlamydia trachomatis. Recently, Nucleic acid amplification methods based on commercial Polymerase chain reaction (PCR) and the Ligase chain reaction (LCR) have been reported to offer improved performance over culture [3] and non culture Chlamydia test methods such as Direct fluorescent antibody assays (DFA) and Enzyme-immunoassay (EIA)[4-5]. High prevalence of Chlamydia trachomatis urogenital infections in the developed world is well documented. The actual prevalence in Indian subcontinent is yet to be determined, although scanty information is available[6]. However, the high reagent and labour cost associated with PCR and LCR may limit their usefulness for broad-based screening for Chlamydia STDs. Since there is no published report regarding he prevalence of Chlamydia trachnomatis female genital tract infections in Kashmir, therefore this study was undertaken to know the prevalence in this region. This article reports a comparative evaluation of the performance of a commercially available EIA with DFA for the diagnosis of infections due to Chlamydia trachnomatis in women attending routine obstetrics and gynecology clinic. The data have been analyzed in relation to clinical findings.

Materials and Methods

Population surveyed: From June 2001 and May 2003, a total of 120 patients were sampled for Chlamydia trachomatis from Obstetrics and Gynecology clinic of SKIMS Medical College Bemina, Srinagar.Since the study was confined to female reproductive age group only, so men were excluded from the study. All patients were married. Fifty matched female healthy controls were also included in the study. The patients were divided into three clinical groups.

Group I (n=65) ---------- Mucopurulent cervicitis
Group II (n=34) ---------- Pelvic inflammatory disease
Group II (n=65) ---------- Vaginitis with excessive vaginal discharge.

All the above patients were clinically evaluated besides performing complete gynecological examination and findings were recorded on a Proforma. Ethical clearance was obtained from the ethical committee of host institute.

Specimen collection: Duplicate endocervical specimens were collected from women usinga cytobrush for DFA test and Dacron swab for EIA. The exocervix was first cleaned with Dacron swab to remove excess mucous and exuadates. Cytobrush and Dacron swab respectively were inserted into the endocervical canal rotated against the wall for 5-10seconds and removed avoiding contact with any viginal surface. Slides from cytobrush were prepared immediately after specimen collection. The Portion of cytobrush containing the specimen was placed across the centre of the well. The brush was twisted and rotated

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Key words: Chlamydia trachomatis, EIA, DFA.

Table 1
C trachomatis antigen carriage (%age) in patients and controls using EIA

Age (year)	Cervicitis cases Screened	Positive	PID Cases Screened	Positive	Vaginitis cases Screened	Positive	Controls Screened	Positive
20-25	10	0	4	0	2	0	10	0
26-30	15	2(13.3%)	8	0	2	0	10	0
31-35	16	5(31.2%)	10	3 (30%	7	1	10	0
36-40	12	5 (41.6%)	9	0	7	0	10	0
41-45	12	1 (8.3%)	3	0	3	0	10	0
Total	**65**	**13 (20%)**	**34**	**3.(8.8%)**	**21**	**1**	**50**	**0%**

Table II
C. trachomatis antigen carriage (%age) in patients & controls using DFA

Age (Years)	Cervicitis cases Screened	Positive	PID cases Screened	Positive	Vaginitis cases screened	Positive	Controls Screened	+ve
20-25	10	0	4	0	2	0	10	0
26-30	15	1(6.6%)	8	0	2	0	10	0
31-35	16	6(37.5%)	10	2 (20%)	7	1	10	1
36-40	12	5 (41.6%)	9	1(11.1%)	7	0	10	0
41-45	12	1 (8.3%)	3	0	3	0	10	0
Total	**65**	**13 (20%)**	**34**	**3.(8.8%)**	**21**	**1**	**50**	**1%**

Table III:
Overall prevalence in different clinical groups

Clinical groups	No. of cases screened	True positives	Prevalence
Cervicitis	65	13	20%
PID	34	3	8.8%
Vaginitis	21	2	9.5%
Total	**120**	**18**	**15%**

Discussion

Prevalence of genital infections with Chlamydia various depending upon the population studied and the sensitivity of laboratory methods used. The 'gold standard' for detection of Chlamydia is still consideration by many to be cell culture. Culture is 100% specific, but estimates of sensitivity are as low as 50%. The majority of laboratories have moved away from culture, as it is expensive, time consuming and technically difficult, because of these reasons and also because of non-availability of culture in our laboratory, use of an expanded gold standard i.e diagnosing Chlamydia evaluation of EIA and DFA was done as has done earlier also by Russel et al.

The ease of use and cost of EIA and DFA make them practical tests for women seeking routine gynecological care. These tests have been more thoroughly evaluated and used in some settings without culture. In our study, EIA was put up side by side for comparative evaluation with DFA, as it is of tremendous value for screening Chlamydia antigen carriage at centers where fluorescent microscope is not available. The lower expense and easier performance of an EIA test facilities routine screening. This procedure also offers several advantages over

Isolation techniques. Isolation of chlamydia trachomatis in Mc. Coy cell cultures is expensive, technically difficult and it requires a minimum of 48 hours to perform. Further more, only few institutions have the necessary equipment and properly trained personnel for it. In contrast EIA is rapid (4 hours) simple procedure well suited for large-scale research projects because many specimens can be easily tested at one time. EIA & DFA were put up simultaneously because earlier reports also denote that no single technique detected all the infections and thus emphasis has been given on doing two or more tests.[8] Uyeda et al [9] have shown DFA to be 96% sensitive and 99% specific when compared to culture. Also Tam and Colleagues [10] have reported sensitivity and specificity of DFA at 92% and 97% respectively when compared with culture.

Age group of 26-40 was found more prone to infections in our study which is in contrast to the literature available from western setups where prevalence is reported higher in younger age groups. This could be because of restriction of our study to women of reproductive age group who were married

. Sensitivity and specificity of EIA and DFA tests in our study is comparable to that shown by other workers for women in similar settings. Chlamydia trachomatishas been isolated from 4.6% to 22% by other observers also, in women attending gynecological

Muscle Herniation in Lower Limb

V Bhattacharya; Seema Khanna; Sheikh Adil Bashir; Sunish Goyal; Umesh Kumar.

Abstract:

Muscle herniation of the lower limb is a rare clinical entity and should be considered as a differential diagnosis when a soft tissue swelling is encountered in the extremities. The tibialis anterior is more commonly involved followed by the gastrocnemius. Diagnosis is mainly clinical and is confirmed by ultrasonography. Treatment requires the repair of the fascial defect. If the surrounding fascia is thinned out or the defect is large, reinforcement with fascia lata is preferred over prosthetic mesh. Five cases of lower limb hernia are presented.

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Introduction:

Herniation of muscle represents focal muscular protrusion through an acquired or congenital defect in the deep fascia. Although muscle hernia is not a new entity, it has received little attention in the medical literature. With increased public awareness in physical fitness, the plastic or orthopaedic surgeons encounter more of such cases[1].

Muscle hernias occur more frequently in the lower than the upper extremity. These hernias vary in size from a cm to larger sizes. The most frequent muscle hernia of lower extremity is that of the tibialis anterior[2]. The other muscles, which may herniate are the gastrocnemius and the peroneus brevis. Bilateral multiple muscle hernias of the legs resulting from regular, intense physical exertion have been reported[3].

Treatment is usually necessary for troublesome symptoms or for cosmetic reasons. When conservative management, with elastic support and restriction of exercise, is not effective, surgical treatment should be contemplated.

Case Reports:

Out of five patients, three presented with gastrocnemius and two with tibialis anterior muscle herniations. All of these had persistent symptoms inspite of conservative therapy necessitating surgical treatment. None of our patients requested management for cosmetic reasons. Three illustrative cases are detailed below.

Case: One

A girl of twelve years, presented with a 4 x 4 cm soft swelling on the left calf of six months duration. On examination, there was a 4 cm long vertical scar over the swelling. She gave history of incision and drainage for an abscess in the same region one year back. The swelling was non-tender, soft in consistency, reducible, without any sign of inflammation and the overlying skin was free. She had a limping gait and complained of discomfort on prolonged walking.

Case: Two

A 26-year male farmer presented with a bulge over the right calf for five years . A diffuse swelling gradually developed which was soft in consistency, non-tender and became more prominent on plantar flexion of foot. He complained of dragging pain, and fatigue particularly during physical activity in the fields.

Case: Three

A 25 years old tourist guide developed swelling of left tibialis anterior spontaneously three years back. It gradually increased in size causing pain and cramps hindering his profession. On examination, herniation with distinct wavy contraction of the muscle was observed which enhanced on dorsiflexon of ankle. A video recording of this finding was made.

All the five cases were diagnosed clinically and confirmed by ultrasonography. In the first case, it was iatrogenic which developed following an incision and drainage procedure. This could have damaged the deep fascia overlying the gastrocnemius muscle leading to muscle herniation. In the second and third cases, no definite attributable cause was found. Probably there was inherent weakness of deep fascia coupled with chronic stress of excessive physical activity. Normally, in ultrasonography, the continuity of the deep fascia over the muscle can be observed. (Fig: 1a). In these patients we observed hypo echoic shadow with loss of continuity of the deep fascia over the muscle. Muscle protrusion on active limb movements confirmed muscle herniation.

The first two cases were operated under local anesthesia. Through a lazy S incision, the skin and subcutaneous tissue over the swelling was undermined to expose the fascial defect. In the first patient, there was a 4 x 4 cm defect in the deep fascia through which the gastrocnemius muscle was herniating. The deep fascia around the hernia was of normal thickness. The deep fascia was incised by 1 cm at the superior and inferior ends of the hernia to allow adequate subfascial dissection of deep fascia on either side of the defect. Adequate undermining of edges was performed for a tension free closure. The fascia was sutured in double breasting manner over the reduced muscle using 3/0 prolene to repair the

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Key Words: Muscle herniation, Lower limb, Tibialis anterior, Gastrocnemius, Deep fascia, Ultrasonography

Fig. 1

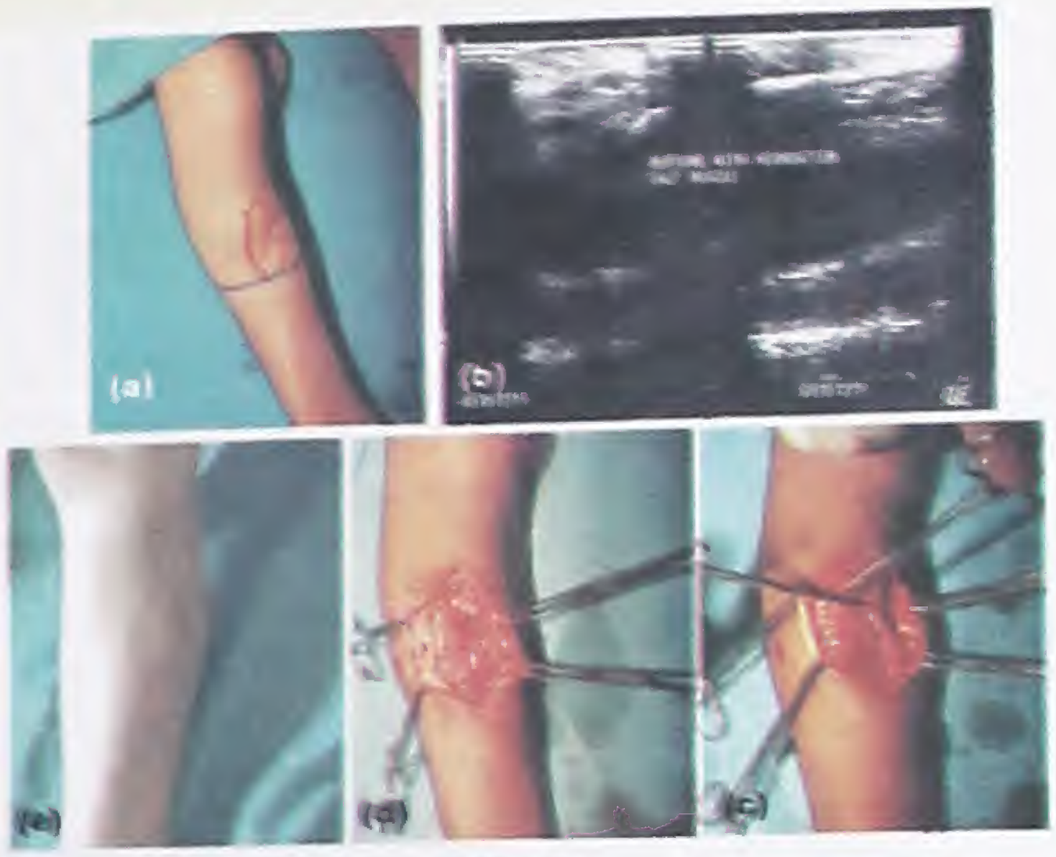

Fig. 2

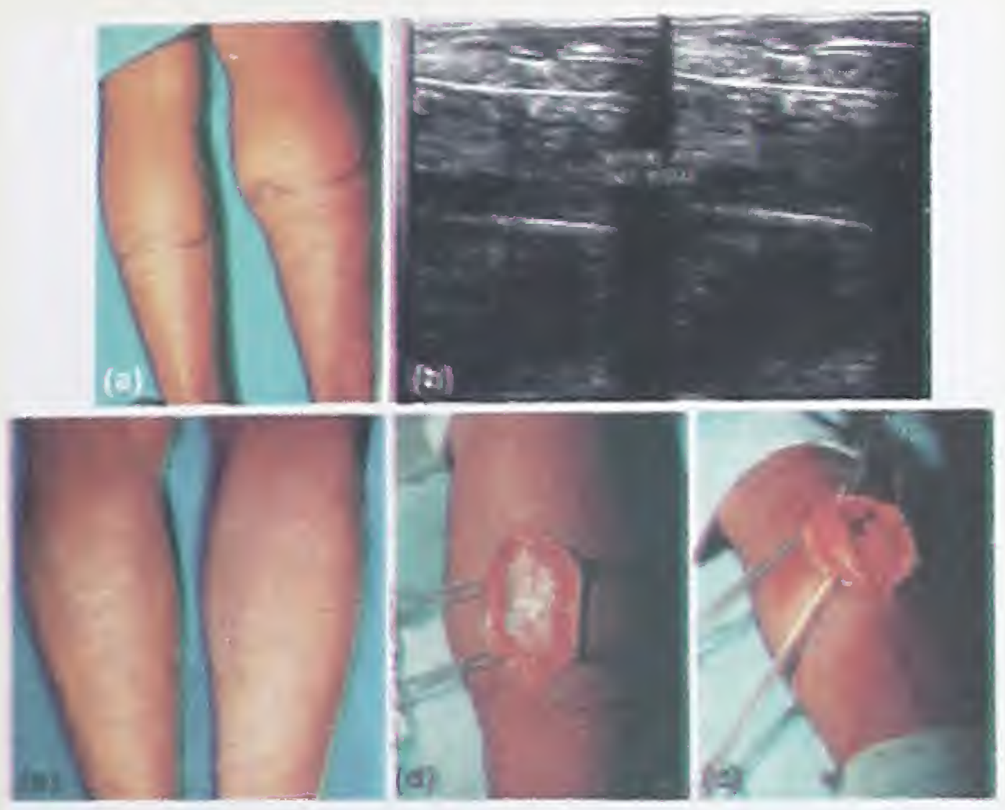

Fig. 3

Fig. 4

Fig 1: Showing deep fascia over gastrocnemius muscle in a normal person.

Fig 2 (a): muscle hernia through incised scar. **(case1)**

(b): Ultrasound showing discontinuity of deep fascia and muscle herniation.

(c): Explored hernia with normal adjacent deep fascia.

(d): Repaired by double breasting.

(e): Follow-up result.

Fig 3 (a): Spontaneous herniation of right gastrocnemius **(case 2)**

(b): Ultrasound showing discontinuity in deep fascia.

(c): Thinned out deep fascia adjacent to hernia.

(d): Double breasting repair.

(e): Post operative result

Fig 4: Large hernia of left tibialis anterior **(case 3)**

hernia (Fig 2 a,b,c,d,e) and the wound was closed.

In the second case, the hernia was measuring 6 **X** 4cm. The deep fascia around the hernia was thin which was dissected carefully (Fig. 3 a,b,c,d,e). Although, we thought of using tensor fascia lata, to strengthen the site but were able to repair it satisfactorily in the above manner.

In case three ,the fascial defect was 10 cms long and 4 cms wide through which a large bulk of tibialis anterior was herniating (Fig 4). Hence, a tensor fascia lata strip of 12 x 6 cms was harvested and sutured on the suprafascial surface of deep fascia all along the hernial margin in proper tension after reducing the muscle.

Skin sutures were removed after 12- 14 days. All the patients were prescribed pressure garment postoperatively for 3 months and during this period, strenuous movements were restricted. None of the patients had recurrence at one year follow-up. All the symptoms disappeared and no bulge was visible at the site of the hernia.

Discussion:

Muscle herniation may be post traumatic, post infective or spontaneous. It could be the result of a penetrating injury or a consequence of trauma to a contracted muscle, which may cause rupture of the fascia without breakage of the skin. Spontaneous hernias, on the other hand, could be the result of chronic stress due to regular, vigorous physical exercise with consequent muscular hypertrophy and elevated intra compartmental pressure. There may be inherent weakness and thinning of the deep fascia, as was observed in Case 2.

Ultrasonographic examination is performed to confirm the physical findings of muscle herniation. Exercise enhances the sonographic visualization of the fascial defect and the associated muscular herniation[4]. The sonographic technique demonstrates the muscle bulging out through the fascial defect. Dynamic examination permits demonstration of reduction of the herniated muscle substance when pressure is applied through the ultrasonic probe[5]. MRI allows recognition of herniated muscle and identification of the fascial defect[6]. However, most of the time clinical evaluation is sufficient for diagnosis.

All our patients visited with definite symptoms causing problems in their routine life. We feel that these hernias initially should be managed by conservative method. If they continue to be symptomatic, they should be treated surgically. Various treatment modalities have been suggested. Direct suture of the fascial defect is reported to carry a higher risk of recurrence. That is why we feel that repair with double breasting of the deep fascia is essential. Bloem[7] suggested enlargement of fascial opening for 10 cm distally and proximally. This is likely to cause adhesions between the muscle and subcutaneous tissue leading to localized skin depression on contraction of the muscle. Siliprandi et al[2] used Mersilene mesh for the surgical repair of a tibialis anterior hernia. Mesh was placed over the fascia to allow muscle to glide on a smooth surface without any friction against the mesh margins and the sutures. Smola suggested excision of part of the muscle to reduce its volume[2]. We feel there is minimal justification for such a procedure where normal functional muscle unit is sacrificed. Boriani used a turned over periosteal flap from medial side of tibia for tibialis anterior muscle herniation[2]. For obvious reasons, only a defect less than 3 - 4 cm can be repaired with this flap. Fascia lata has also been employed with the relative disadvantage of a scar on the lateral thigh[8].

All our cases had different findings. In case 1, the post infective defect was smaller and the adjacent fascia was strong. So double breasting was done. In case 2, the spontaneous herniation due to over exertion was larger and the deep fascia was thin although he was 26 years as compared to the case 1 who was a 12 years old girl. However, during operation we could repair the deep fascia satisfactorily by the same technique. The technique is simple and provides a good functional and cosmetic result. We have not observed any evidence of compartment syndrome following repair of deep fascia. In the third case the hernia was larger and substantial amount of muscle was herniating. So tensor fascia lata strip was used to reinforce and the result was gratifying. We feel that autologous similar tissue should be preferred. Fascia lata is a large source of such tissue with the only disadvantage of a linear scar.

All our patients have been followed up regularly for more than 12 months and none has had a recurrence. The third case, a tourist guide, has opted for a less strenuous job.

In conclusion, muscle herniation should be considered as a differential diagnosis when a localized soft, non-tender swelling is found in the muscular part of an extremity. The diagnosis can be confirmed by ultrasonography. Treatment requires delineation of hernia and repair of the fascial defect in double breasting manner by non-absorbable suture. If the surrounding fascia is thinned out or the hernia is large, reinforcement with fascia lata gives gratifying result.

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Assessment of Psychological Distress in Patients Undergoing Assisted Reproductive Treatment

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Shahla Maasoumi Moghadam, Fatemeh Ghaedi, Shahla Maasoumi Moghadam, Fatemeh Ghaedi, Shahla Maasoumi Moghadam, Fatemeh Ghaedi

Background: Infertility is a crisis that affects the individual's psychological balance and can lead to psychological distress. Assisted reproductive treatment is a stressful process for infertile couples. Psychological distress can affect the outcome of assisted reproductive treatment. The aim of this study was to assess psychological distress in patients undergoing assisted reproductive treatment.

Materials and Methods: This descriptive study was conducted on 200 infertile women undergoing assisted reproductive treatment in Isfahan, Iran, in 2015. Data were collected using the Depression, Anxiety and Stress Scale (DASS-21) questionnaire. Data were analyzed using SPSS software version 16 and descriptive statistics.

Results: The mean age of the participants was 31.5±5.2 years. The mean duration of infertility was 6.8±4.1 years. The most common cause of infertility was male factor (42%). The mean scores of depression, anxiety and stress were 12.3±6.5, 10.8±5.9 and 14.2±6.8, respectively. Moderate to severe depression was observed in 38% of patients, moderate to severe anxiety in 32% and moderate to severe stress in 41%. Psychological distress was higher in patients with longer duration of infertility and in those undergoing their first cycle of treatment.

Conclusion: Psychological distress is common among patients undergoing assisted reproductive treatment. Psychological support should be provided to these patients to improve their mental health and treatment outcomes.

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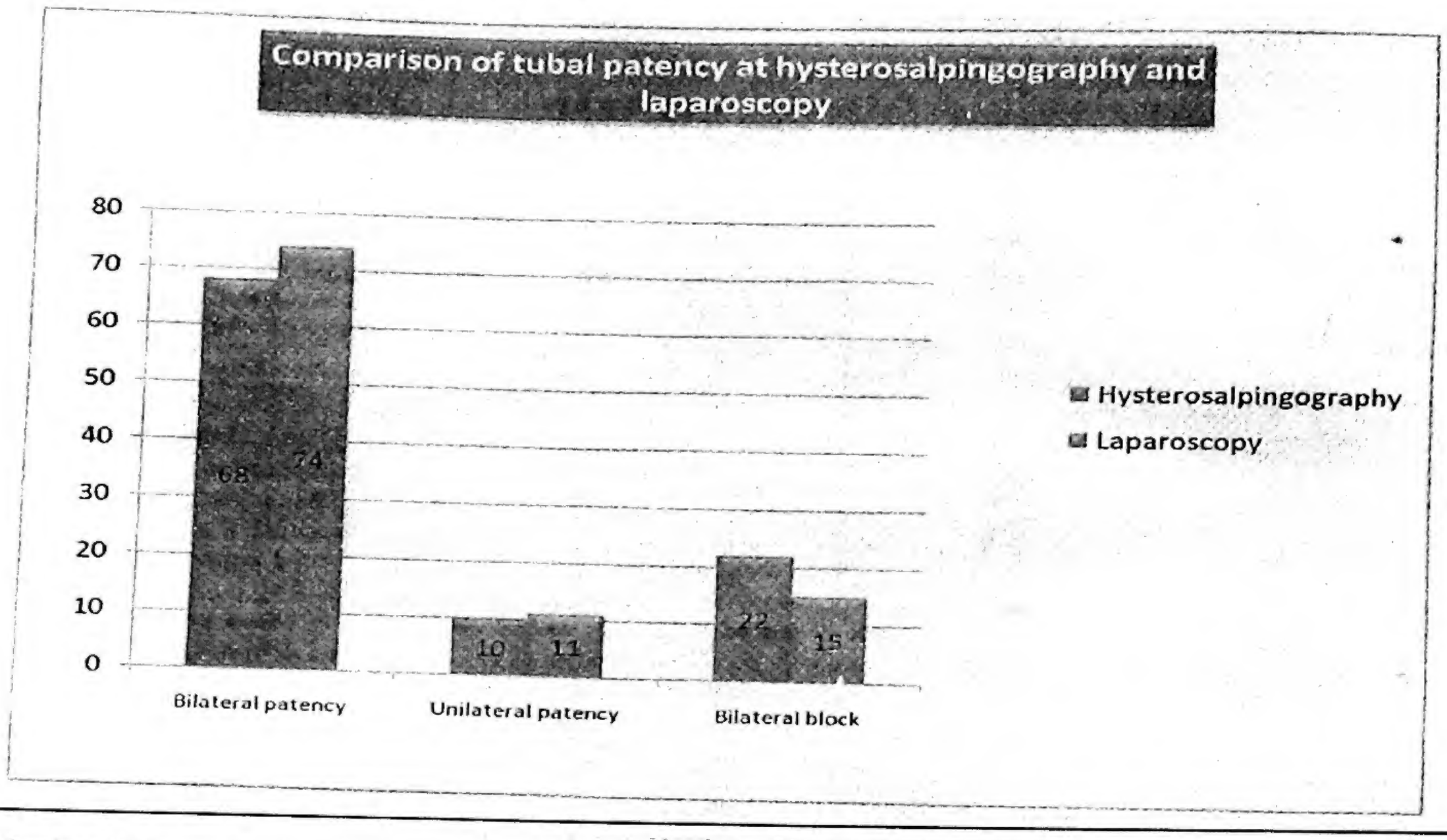
between the two procedures are found in cases with pathologies detected at laparoscopy like fibroid, tuberculosis, endometriosis and PCOD. HSG is primarily an intra-luminal study while laparoscopy is extra-luminal. The two therefore, complement each other in diagnosis.



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Previous Treatment Regimen (Replaced)

Previous Treatment Regimen (Replaced)

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Previous Treatment Regimen

Previous Treatment Regimen

Previous Treatment Regimen

Introduction

Introduction

Introduction

Material and methods

Material and methods

Material and methods

drug-regimen given.

drug-regimen given.

drug-regimen given.

Animal treatment.

Animal treatment.

Animal treatment.

Study Protocol

Study Protocol

Study Protocol

Observations:

Table 1:
Distribution of mode of delivery (MOD) in ante-/ intra-partum eclampsia patients.

M.O.D	Patients treated with			
	P 18	D 19	M 14	Total 51
V.D	13 (72.2%)	15 (78.94%)	12 (85.71%)	40 (78.43%)
L.S.C.S	5 (27.8%)	4 (21.06%)	2 (14.29%)	11 (21.57%)

Table 2:
Distribution of foetal outcome at birth in patients of eclampsia.

	Patients treated with			
Foetal outcome	P 26	D 25	M 19	Total 70
Still births	1 (3.84%)	6 (24%)	1 (5.26)	8 (11.42%)
Intra-uterine growth restriction births	1 (3.84%)	1 (4%)	0 (0%)	2 (2.86%)
Premature births	7 (26.92%)	7 (28%)	4 (21.06%)	18 (25.72%)
Normal live births	17 (65.38%)	11 (44%)	14 (73.68%)	42 (60%)

P = Number of patients receiving I/V phenytoin regime
D = Number of patients receiving I/V diazepam regime
M = Number of patients receiving I/V low dose magnesium sulphate regime.
T = Total number of patients in each group.
The values in parenthesis are percentage values
Significant difference = P= 0.05

There was a significant difference (P= 0.05) in still births in P, D,M group. Maximum foetal mortality occurred in diazepam group (i.e. 24%) with minimum in phenytoin group (3.84%).
Overall foetal mortality was found to be 11.42% in eclampsia.

Table 3:
Distribution of foetal outcome at 2 weeks.

	Patients treated with			
Foetal outcome at 2 weeks	P 25	D 19	M 18	Total 62
Alive	18 (72%)	11 (57.9%)	16 (88.89%)	45 (72.58%)
Neonatal death	7 (28%)	8 (42.1%)	2 (11.11%)	17 (27.41%)

P = Number of patients receiving I/V phenytoin regime
D = Number of patients receiving I/V diazepam regime
M =Number of patients receiving I/V low dose magnesium sulphate regime.
T =Total number of patients in each group.The values in parenthesis are percentage values

The above data suggests that 42.1% of babies born of eclamptic mothers treated with I/V diazepam have a neonatal death, while only (11.11%) of babies die when mother's have been treated with I/V magnesium sulphate. Overall 72.58% of live babies born of eclamptic mothers survive till at 2 weeks of age.

The overall results obtained by this are study similar to that of Maheshwari JR Desai et al (1989)[12]. The proper and timely management of eclampsia with early referal can improve the foetal and maternal outcome in such patients. Hence better antenatal care facilities in the peripherial health centres is the need of hour.

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hypoosmolality: hypothyroidism, hypocortisolism and diuretic use.

Hypoosmolality is primarily associated with a broad spectrum of neurologic manifestations, ranging from mild, nonspecific symptoms (e.g., headache, nausea) to more significant disorders (e.g., disorientation, confusion, obtundation, focal neurologic deficits, and seizures). This neurologic symptom complex has been termed hyponatremic encephalopathy and primarily reflects brain edema resulting from osmotic water shifts into the brain because of decreased effective plasma osmolality. Significant neurologic symptoms usually do not occur until serum [Na+] falls below 125 mEq/L, and the severity of symptoms can be roughly correlated with the degree of hypoosmolality. However, individual variability is marked, and for any single patient, the level of serum [Na+] at which symptoms appear cannot be predicted with great accuracy. In the most severe cases of hyponatremic encephalopathy, death results from respiratory failure after tentorial cerebral herniation and brainstem compression. Clinical studies also have suggested that menstruating women and young children may be particularly susceptible to the development of neurologic morbidity and mortality during hyponatremia, especially in the acute postoperative setting.

The risk is more in women with other medications being concomitantly prescribed such as thiazide diuretics, carbamazepine, oral hypoglycemics and several other drugs. Some other disorders such as Tuberculosis, Pneumonia, hypothyroidism, brain tumors and other illnesses are also associated with SIADH . The risk is also more in the summer months[4].

Patients, in particular elderly patients, should have their serum sodium concentration monitored, especially in the early stages of treatment with SSRI. Hyponatremia and SIADH should be considered if a patient experiences deterioration in his or her clinical condition while taking an SSRI, regardless of the duration of treatment. The use of SSRI antidepressants should be remembered in the differential diagnosis of drug-induced hyponatremia.

In the case reported above none of the risk factors for hyponatremia including the use of mood stabilizing drugs was present, however biochemical hypothyroidism noticed initially could be a risk factor not reported earlier. The mechanism by which such drugs induce SIADH is not clear but it is believed that an increase in serotonin causes a greater renal excretion of sodium, which accounts for the higher urinary osmolality[5].

The initial signs of hyponatremia are often of weakness, dizziness, sweating, crampy abdominal pain, lassitude and anorexia, all of which may be seen as symptoms of depression. As a consequence the hyponatremia may be altogether missed. Hence it is recommended that the elderly not responding to SSRI or actually worsening on the same must be monitored for hyponatremia and thyroid function tests.

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Case Report

Case Report

Case Report

Case Report

Case Report

Case Report

The case of double appendix in a 57-year-old male is probably report of appendicular duplication in the oldest patient reported so far and because the patient was asymptomatic it favours the absence of other congenital anomalies. Since the patient was lost to the follow up he could not be evaluated further for the presence of other congenital anomalies.

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Diprosopic Parapagus (Monocephalic Diprosopos)

Chander Sheikher; Mohd Ashraf; Nitasha Suri

Conjoined twins are defined as monochorionic and monoamniotic twins fused at any portion of their body as a result of incomplete division of embryonic disc which occurs after the 13th day of conception. The term conjoined twin is actually a misnomer, since most of the authors consider the pathogenesis of the condition to result from failure of complete separation, instead of fusion of twin.

Diprosopic parapagus: It is a term coined when there is lateral union of the twin having a single trunk and single head with two faces.

A term appropriate for gestational age female was born to a 35year old female by LSCS, who was a multigravida, had documented history of polyhydramnios.

On clinical examination of neonate revealed one skull, two anterior fontenella, two noses, two ears two mouths, two chins, four eyes, of which medial two were very near. There was one dimple at junction of two faces (Fig 1and 2). There was high arched palate with no other intra-oral abnormality and both stomas were separated by a movable muscular septa. Neonate had broad neck, one spine, two arms and two legs with no other apparent anomaly. Neonate weighted 2.8 kgs, crown heel length of 48 cm and occipetofrontal circumference of 41cm.A diagnosis Diprosopic Parapagus (Monocephalic Diprosopos) was made. Neonate died 45 minutes after delivery. This is extremely rare variety of conjoined twins not found reported in most of literature to best of our knowledge.

Fig. No.: 1

Fig. No.: 2

This is most uncommon and very rare variety of conjoined twins. Incidence of conjoint twins is one in every 40,000 births, but only one in every 100,000 to 200,000 live births. Sixty percent of conjoined twins are either stillborn or lost in utero and 35% twins that survive birth die within 24 hours. Conjoined twins are most likely to be female (71.62% are girls and 28.38% were boys), since it has been associated with X-chromosome . Incidence is highest in Africa and India[1]. Conjoint twins are supposed to be cause by an interplay of genetic and environmental factors, like Agent Orange, and Assisted fertilization techniques (IVF, ICSI)[2]. In addition, conjoint twining is also is related with the day of differentiation and separation of chorion and amnion[3].

In one attempt to universalize the current nomenclature, a new classification was proposed recently based on theoretical site of union as :- **Ventral Union,Lateral Union or Dorsal Union**

Ultrasonographic evaluation of fetus during pregnancy carries an immense importance as suspected cases in which, there is lack of separating membrane, <2, or >3 cord vessels, separate fetal body parts, and backward flexion of cervical spine, bifid appearance of fetal pole, presence of fetal anomalies, unusual proximity of extremities, single heart, permanent position of fetus relativeto one another, even after external stimulation or maternal movement, hence can be accordingly decided[4].

Prognosis, Obstetric management, and treatment planning are determined by degree of fusion and extent of joint of fetal organs[5].

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Congenital Adrenal Hyperplasia 21 Hydroxylase Deficiency

R P Kudyar; Sidharath Kapoor; Surbi Kudyar; Pankaj Batra.

We report a patient of 21 hydroxylase deficiency. A 4 ½ year old boy was brought by his father with complaints of hoarseness of voice and increased linear growth since last two years. What bothered the parents was observation that the child is attaining sexual maturity and had started showing abnormal behaviour when compared to his pears.
Phenotypically, the child looked quiet grown up exhibiting the following features.

Face (look), hands and feets well developed (adult like features).

- Axillary hair.
- Coarse, curly pubic hair.
- Well developed phallus with relatively small sized testis.
- Falling Milk teeth.
- Hoarse voice.
- Masculine body well developed muscles especially arms, pectorals, masculine facial features.

ON EXAMINATION: -
Afebrile, HR-90/mt., BP-110/80 mmHg (Right arm Supine).
Sys. Exam Unremarkable.
Chest-Clear, CVS-S1S2 +.
P/A-soft, non-tender, BS+. CNS-NAD.

ANTHROPOMETRY:
Height = 136cm
Arm Span = 136 cm
Crown rump length = 60 cm
Unstretched Phallus (Penile) length = 8.5 cm.
Right Testis: 8 x 17 mm
Left testis: 8 x 17 mm

SEXUAL MATURITY RATING: 4 to 5

1. Coarse curly pubic hair.
2. Axillary hair
3. Scrotal Rugosity
4. Size of penis 8.5 cm (Unstretched).

INVESTIGATION (RELEVANT INVESTIGATION) : Hb-12gm%, TLC-9000/cmm, FBS-78 mg/dl, Urea-20 mg/dl, Creatinine-0.8 mg/dl, P/P-92 mg/dl, Free Testosterone (by Radio immuno assay method)-19.99 Pg/ml (7.2 to 23 Pg/ml), LH-0.07 mIu/ml (1.5 to 9.3 mIu/ml), FSH-0.30 mIu/ml (1.4 to 18.1 mIu/ml). (LH & FSH by Chemiluminescence's method).
17-hydroxy Progesterone (by Radio immuno assay method) = 45.62 (3 months to 11 years - Not detectable to 0.90 ng/ml).
DHEA Sulphate (by Chemiluminescence's method) -140 mg/dl (80-560 mg/dl)
Thyroid profile-Normal.
USG (Abdomen): Normal HBS, Pancreas.
Normal KUB, Prostate.
No Suprarenal mass.
(All abdominal organs have dimensions of adult; testes were of relatively small size).

X-ray: Radiological bone age of boy is 14 years.

DISCUSSION: Puberty in boys before the age of 9 is considered precocious.
Isosexual puberty refers to pre-mature sexual development consistent with phenotypic sex. It is divided into gonadotropin dependent and gonadotropin independent causes of androgen excess.
Gonodotropin dependent precocious puberty is also called as central precocious puberty; it is less common in boys. It is caused be premature activation of GnRH pulse generators characterized by gonadotropins levels that are appropriately elevated for age.
GONADOTROPIN INDEPENDENT PRECOCIOUS PUBERTY IS DUE TO: -

1. HCG secreting tumors
2. Congenital adrenal hyperplasia.
3. Sex steroid producing tumors of the testis, adrenals and ovary.
4. Accidental or deliberate exogenous sex steroid administration.
5. Hypothyroidism
6. Activating mutation of LH receptors or GS[] subunit.

In these cases androgons from the testis or adrenals are increased but gonadotropin are low.
The boy who presented to us had an sexual maturity rating score of four to five, which under normal circumstances should be zero, then his radiological bone age is 14 years.
Also, his investigations revealed decreased LH, FSH with elevated 17- [] hydroxy progesterone and significantly elevated testosterone and his testis were of relatively small size whereas all other abdominal organs have dimensions of an adult. Considering the investigations and clinical presentation supported the diagnosis of 21 hydroxylase deficiency in this particular case.

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JK-Practitioner 2008; 15 (1-4): 26

clinical pharmacy
clinical pharmacy

Evaluation of Comparative Effectiveness of Dipeptidyl Peptidase-4 Inhibitors in Patients with Type 2 Diabetes Mellitus: A Comparative Study

Dipeptidyl Peptidase-4 Inhibitors in Patients with Type 2 Diabetes Mellitus: A Comparative Study
Dipeptidyl Peptidase-4 Inhibitors in Patients with Type 2 Diabetes Mellitus: A Comparative Study

Author Name, Author Name, Author Name,

therapy (week 0) and at weeks 6 and 12 of treatment (study end). Patients were advised to report immediately for any unexplained muscle pain, nausea/vomiting, headache or other AEs. At the end of therapy, patients were monitored for AEs for 4 to 6 additional weeks at the department of Pharmacology and Medicine.

Laboratory Procedures:

Laboratory analyses were performed at weeks 0, 6 and 12. Blood samples were drawn after 12 hours of fasting and allowed to clot at room temperature. Serum was assayed by centrifugation at 2000 rpm for 10 minutes at 37°c and used to determine TC levels, followed by HDL-C level after precipitation of very low density lipoprotein cholesterol (VLDL-C) and LDL-C. Blood samples were analyzed using a spectrophotometer (Spectronic 20, Spectronic Analytical Instruments, Garforth, Leeds, United Kingdom) by CHOD/POD-Phosphotungstate method[6] (Monozyme kit, Monozyme India Limited, India). Serum TG level was measured with spectrophotometer by enzymatic method[7] (Lyphozyme kit, Beacon Diagnostic Pvt. Ltd., India). The LDL-C level was calculated using the following formula:[8]

LDL-C = TC HDL-C TG/5

VLDL-C level was calculated by formula:[8] VLDL-C = TG/5

Non HDL-C was calculated by: TC- HDL-C.

Statistical Analysis:

The data were analyzed using the t-test and ANOVA (one way). $p<0.05$ was considered statistically significant.

Observations And Results

Sixty patients were enrolled (31 men, 29 women; 30 patients per treatment group). All patients lived in the state of Punjab, India, with 31 (52%) from urban areas and 29 (48%) from rural areas. CAD risk factors present at baseline are shown in Table I.

Table I
Baseline risk factors for coronary artery disease (CAD) in Indian patients with dyslipidemia (no. {°o})

Group	Hypertension	Smoking	Family H/O CAD	Obesity*	Metabolic Syndrome
I (n=30)	28 (93)	4 (13)	3 (10)	25 (83)	24 (80)
II (n=30)	26 (87)	6 (20)	2 (7)	26 (87)	26 (87)

*Evaluated from waist circumference. Inclusion criteria: Male = >102cm
Female = >88 cm

Comparative Efficacy

Table II
Lipid levels (mg/dl) and percentage changes in Indian patients before and after 12weeks of therapy for dyslipidemia. Data are mean (SD).

Lipid/Time point	Group I (n = 30)	Group II (n = 30)
TC		
Week 0	241.1 (26.51)	242.14 (32.63)
Week 12	173.23 (17.81)	139.8 (14.17)
% Change	28.15	42.26
LDL-C		
Week 0	143.16 (20.37)	147.23 (29.42)
Week 12	99.1 (8.53)	75.03 (9.49)
% Change	30.77	49.03
HDL-C		
Week 0	32.16 (6.12)	31.1 (5.71)
Week 12	42.5 (5.01)	40.2 (7.30)
% Change	32.15	29.26
Non HDL-C		
Week 0	208.66 (25.43)	210.71 (31.79)
Week 12	130.86 (16.73)	102.93 (19.5)
% Change	37.28	51.15
TG		
Week 0	332 (89.68)	319.83 (87.43)
Week 12	163.5 (45.54)	125 (35.16)
% Change	50.75	60.91
VLDL-C		
Week 0	66.4 (17.93)	63.96 (17.48)
Week 12	32.7 (9.10)	25 (7.03)
% Change	50.75	60.91

Clinical Pharmacy
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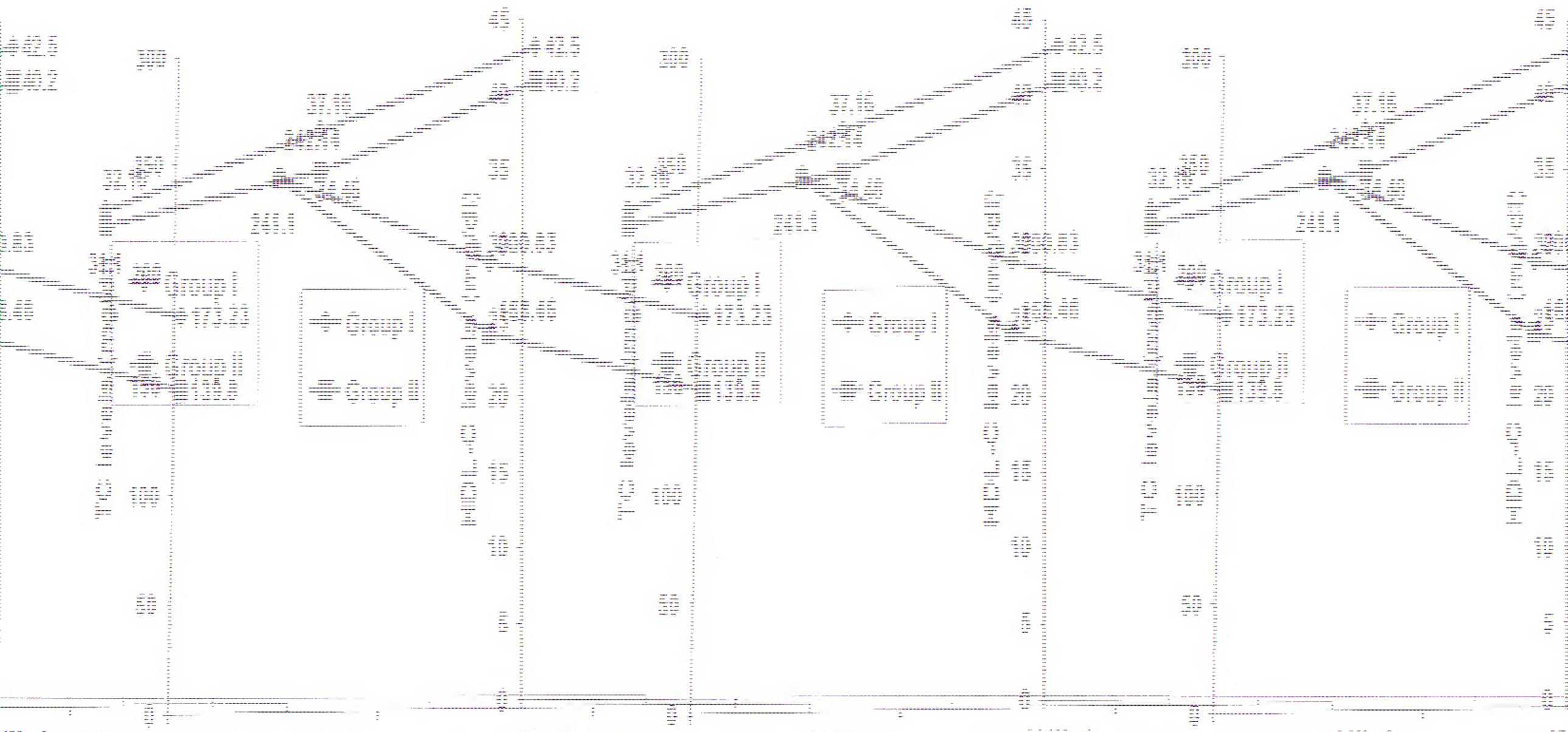
Figure 1.

Figure 1.

Figure 1.



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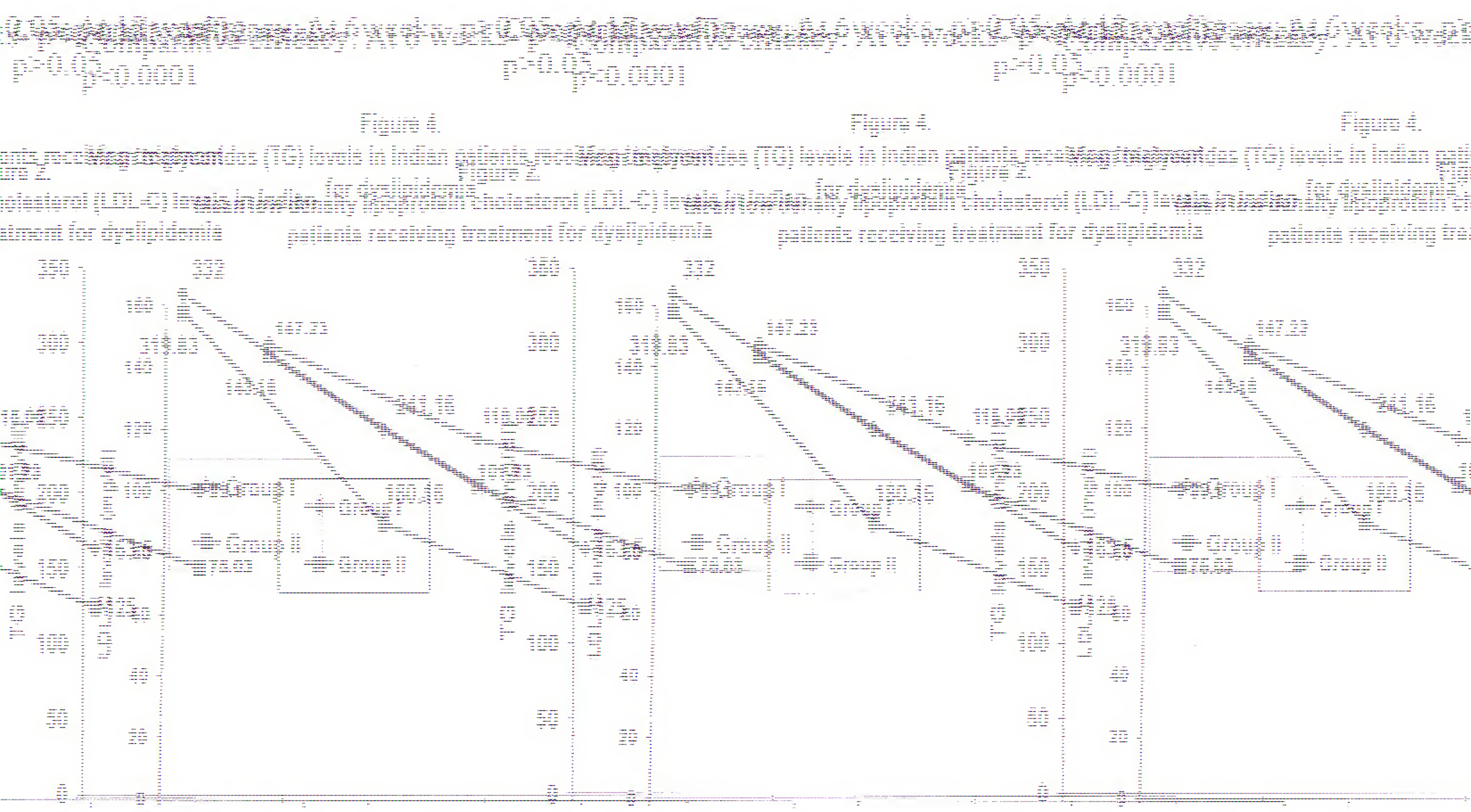

Figure 3.

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Figure 4.

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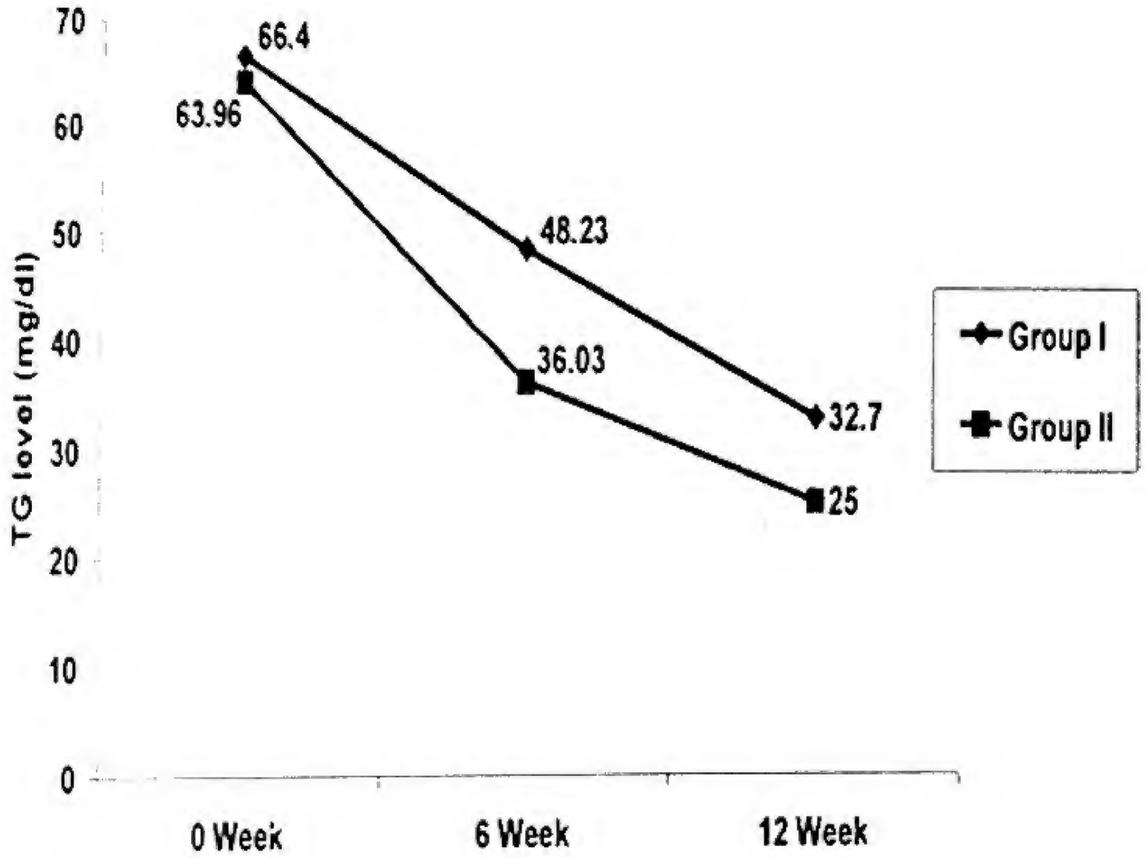
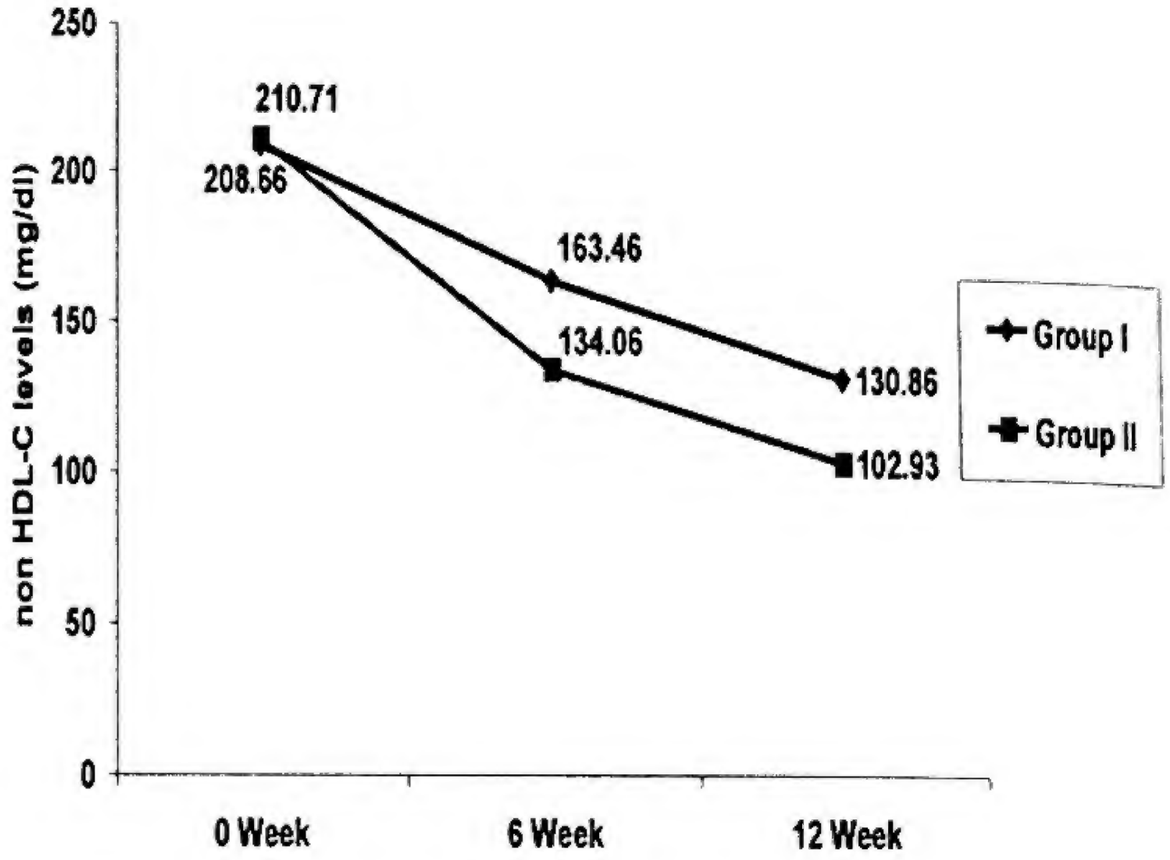
Figure 5.
Mean VLDL-C levels in Indian patients receiving treatment for dyslipidemia



Comparative efficacy: At 6 weeks- $p<0.001$; At 12 weeks- $p<0.001$

Figure 6.
Mean non HDL-C levels in Indian patients receiving treatment for dyslipidemia



Comparative efficacy: At 6 weeks- $p<0.0001$; At 12 weeks- $p<0.0001$

Comparative Change in Lipid Ratios over the Study Period

Table III
Lipid ratios at 0, 6 and 12 weeks and percentage change over the study period

Weeks	TC / HDL-C				LDL-C / HDL-C			
	Group I	% Change	Group II	% Change	Group I	% Change	Group II	% Change
0	7.49	45.66	7.78	55.39	4.45	47.64	4.73	60.67
6	5.40		4.48		3.12		2.93	
12	4.07		3.47		2.33		1.86	

Comparative Efficacy in Cad and Non Cad Patients

Table IV
Changes in parameters of dyslipidemia in CAD patients over the study period

Group	Parameter	TC		LDL-C		HDL-C		TG	
	Weeks	0	12	0	12	0	12	0	12
Group I	Mean	243.70 ±22.95	179.52 ±21.92	141.52 ±16.65	99.29 ±8.50	33.58 ±5.95	43.29 ±5.33	344.41 ±100.4	162.05 ±47.30
	% change	26.33		29.84		28.91		52.94	
	t value	18.313		17.485		7.119		10.88	
	p value	<0.0001		<0.0001		<0.0001		<0.0001	
Group II	Mean	237.52 ±35.60	139 ±16.84	141.47 ±29.82	73.84 ±11.17	31.78 ±6.73	41.15 ±8.40	323.94 ±100.73	77.68 ±36.97
	% change	41.47		47.8		29.48		76.02	
	t value	16.752		13.868		7.229		13.220	
	p value	<0.0001		<0.0001		<0.0001		<0.0001	

Clinical Pharmacy
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TABLE V

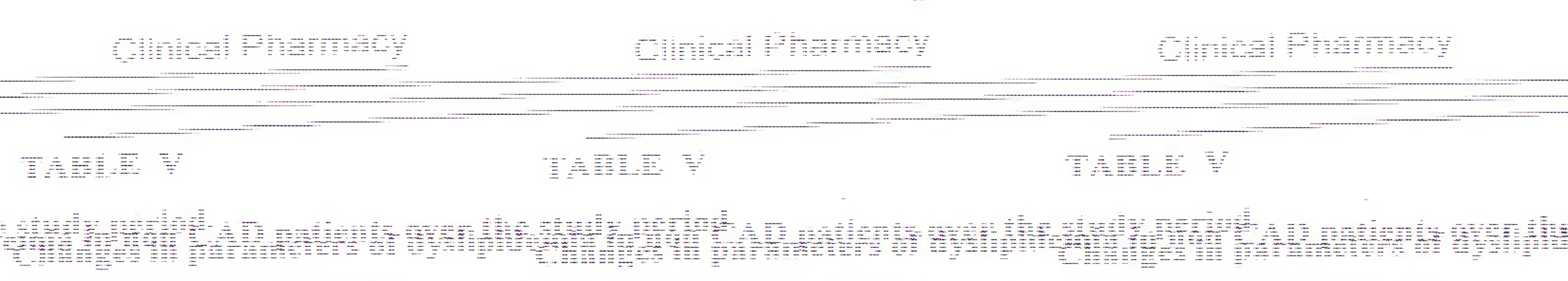

TABLE V

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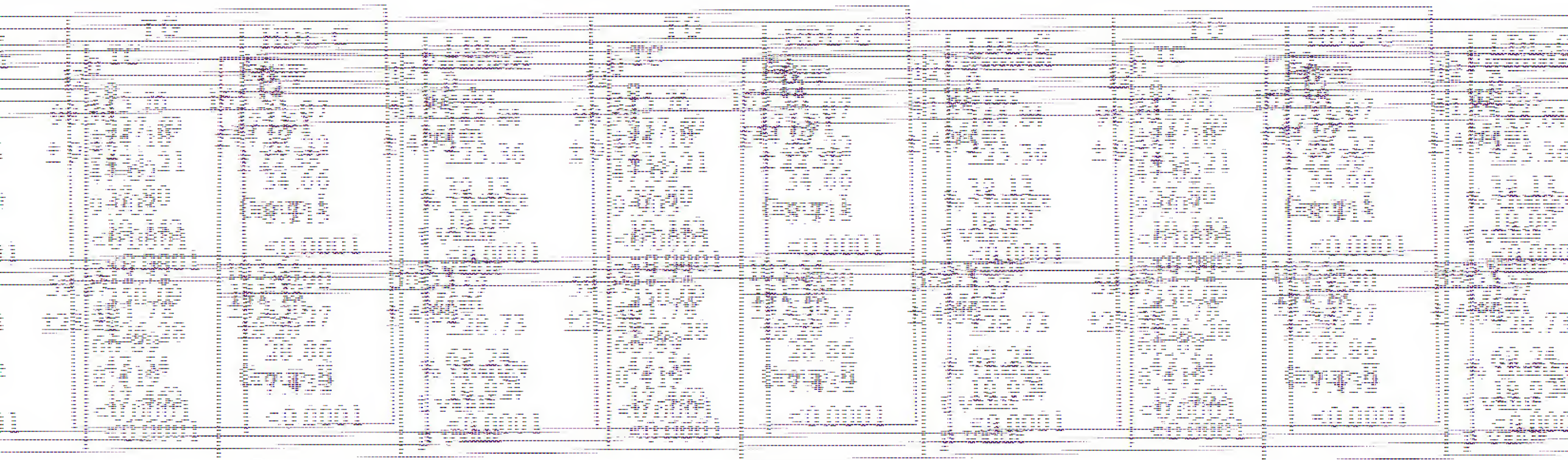

Table VI

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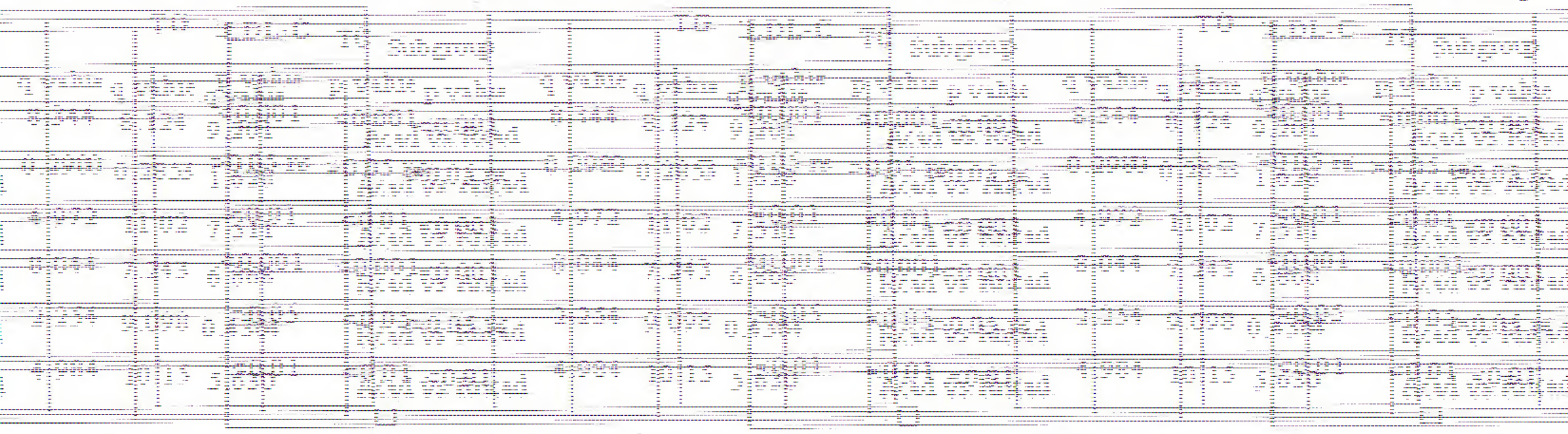

ns : Non significant

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Goals Achieved At 12 Weeks
Table VII

Goals Achieved At 12 Weeks
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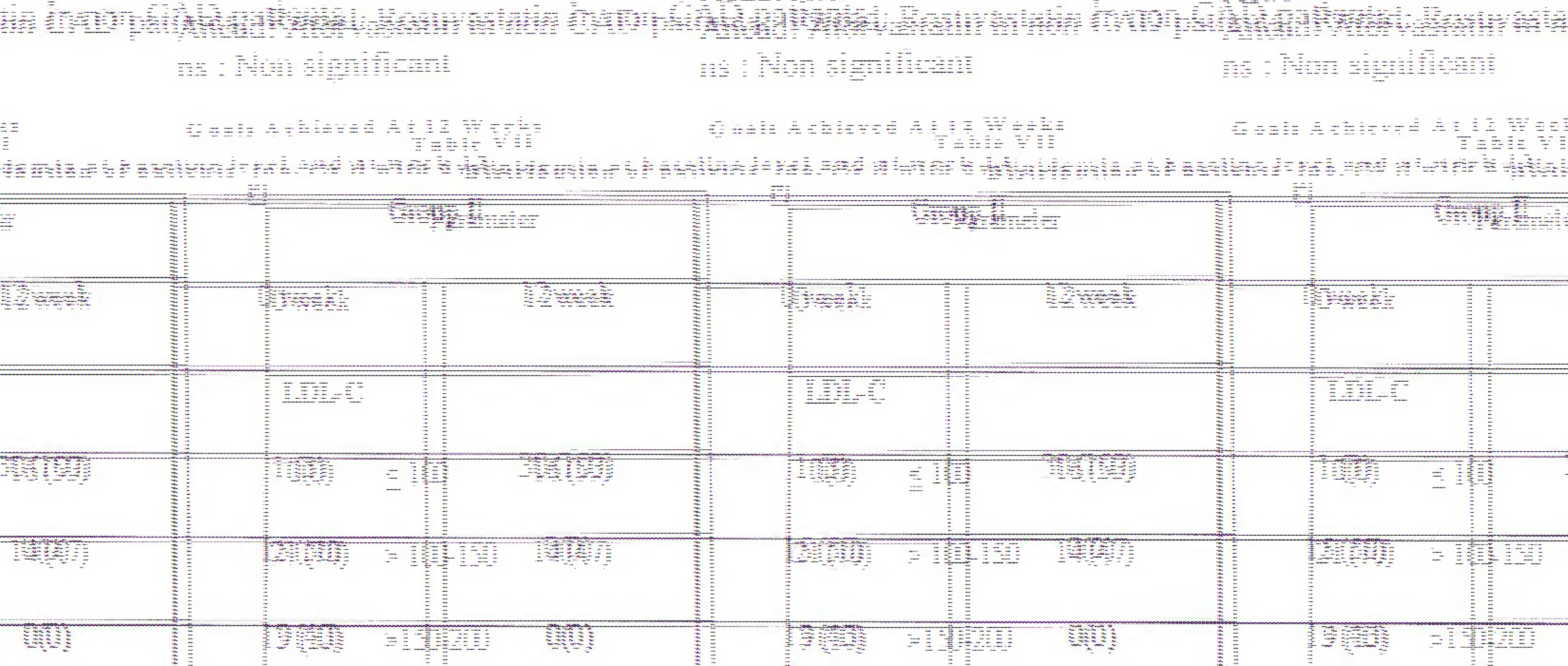
Table VII



<200	3 (10)	29 (97)	3 (10)	30 (100)
>200-250	15 (50)	1 (3)	15 (50)	0(0)
>250-300	12 (40)	0(0)	11 (37)	0(0)
>300	0(0)	0(0)	1 (3)	0(0)
TC				
<150	0(0)	13 (43)	1 (3)	25 (83)
>150-200	2 (7)	11 (37)	1 (3)	3 (10)
> 200-250	7 (23)	5 (17)	6 (20)	2 (7)
>250	21 (70)	1 (3)	22 (74)	0(0)

Table VIII

Incidence of side effects in the study groups (no.{ %})

Side effects	Group I	Group II
Nausea vomiting	4 (13)	2 (7)
Headache	3 (10)	2 (7)
Myalgia (mild muscle pain, aches)	2 (7)	5 (17)
Renal pain	0 (0)	0 (0)

Comparative Cost of Drug Therapy

Table IX

Total Cost of 12 Weeks Treatment Per Patient

Group	Cost in Rupees
Group I (Atorvastatin)	250
Group II (Rosuvastatin)	840

atorvastatin (47.85% vs 29.84%). So it is concluded that rosuvastatin is more effective in patients of CAD in decreasing the LDL-C levels and achieving the ATP III goals.

Comparative efficacy in CAD and non CAD patients

From above observations (Table IV,V,VI), it can be concluded that rosuvastatin is more effective than atorvastatin in lowering the levels of TC, LDL-C and TG in both CAD as well as non CAD patients but equally effective when change in HDL-C is considered. Secondly rosuvastatin is significantly more effective in non CAD patients than CAD patients in decreasing the LDL-C levels.

Efficacy and Safety

In this study rosuvastatin 10mg/dl for 12 weeks was associated with significantly greater reductions in TC, LDL-C, non HDL-C, TG and VLDL-C levels compared with atorvastatin 10mg/dl. However difference in increase in HDL-C levels was not significant. Rosuvastatin also caused significantly more reduction in LDL-C levels in CAD patients as compared to atorvastatin. Furthermore, more patients receiving rosuvastatin achieved the ATP III and Asian Indian goals compared with those receiving atorvastatin.

Both drugs were well tolerated. Nausea/vomiting, headache and myalgia (mild muscle pain) were reported in few patients in both groups but difference was not significant. Apart from these, no other side effect was noticed in 12 weeks of the study and during 4-6 weeks of follow up period (Table VIII).

Conclusion

Though rosuvastatin is expensive but it had an overall better effect on lipid profile than atorvastatin. It decreased serum TC, LDL-C, non HDL-C, TG and VLDL-C to significantly greater extent than atorvastatin but its efficacy was equal to atorvastatin when change in HDL-C level was considered. Rosuvastatin was more effective than atorvastatin in lowering the lipid ratios and achieving the targets set by ATP III and proposed Asian Indian guidelines. It was also observed to be significantly more effective in lowering the LDL-C levels in non CAD patients than CAD patients.

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Clinico epidemiological profile of acute organophosphorous poisoning In Kashmir

Nikhat Mumtaz Talib Khan ; Shigufta Qazi ; Javeed Zargar; Shaqul Qamar

Abstract:

To know the clinicoepidemiological profile of acute organophosphorus poisoning in relation to incidence, Age & Sex distribution, Rural & Urban distribution, Mode & Route of poisoning, & frequency of signs and symptoms of organophosphorus poisoning a Prospective study at SKIMS, a tertiary referral Centre was carried out. 147 patients of acute organophosphorus poisoning were admitted on the basis of history & Clinical Examination are included in the study.

Acute organophosphorus poisoning was number first which constituted about 57.42% of total poisoning admission in our hospital. Maximum numbers of patients were in the age group of 2nd & 3rd decade of life. Females constituted maximum number of cases (59.18%) with female to male ratio of 1.45:1. The poisoning was suicidal in 62.58% and accidental in 37.4% of cases. Commonest route of consumption was oral 98.63%. Maximum numbers of cases were from rural areas to tune of 80.27%. The poisoning produced varied clinical manifestations which were due to exaggeration of cholinergic effects at varied sites.

The patients were managed on the lines of acute organophosphorous poisoning (general measures like decontamination, gastric lavage, atropininisation, Pralidoxime infusion & ventilatory support if required. Hemoperfusion was not done in any of the patients.

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Introduction:

Acute poisoning is a common and acute medical emergency both in developed and developing countries of the world. Poisoning-accidental, suicidal, homicidal has been known in the history of pharmacopica as early as 460 B.C. Abanos in thirteenth century described poisoning caused by animals, vegetables and minerals (R.S.Saxena 1989)[1]. In the modern context poisoning is divided into that due to agricultural, medicinal, household and natural poisons.

Acute poisoning is more common in females than in males in all groups (A.A.H.Lawson 1991)[2].

Different types of acute poisoning with their relative frequency in patients are known. In young children particularly below age of 5 years, they are virtually all accidental, whereas in older age groups the majority are intentional and self inflicted (suicidal) and homicidal also.

The major rise in incidence has been among the patients in second and third decade for different reasons - The varied psychosocial trauma.

Poisoning due to organophosphorous compounds is an increase in India (Park K 2000)[3]. Intoxication may occur following absorption via GIT, respiratory tract or skin. Absorption through skin may occur in sprayers and handlers. The extensive use of organophosphates in agriculture as insecticides has lead to the development of number of organophosphorous compounds, which in turn has introduced human life to rise of huge series of these poisons.

The organophosphorous compounds are broadly classified as *Alkyl Phosphates* (HETP, TEPP, OMPA,Dimefox, Isopestos, Malathion, Sulfotepp, Systox, Diptinix) & *Aryl Phosphates* (Paraoxon, Parathion, EPNO-ethyl-P-nitrophenyl benzene thiophosphonate, Methyl Parathion, Chlorothion-O-O-dimethyl, Diazion, and Methyl Umbelliferone).The most toxic of these compounds has been stockpiled as 'Nerve gases' for possible uses in chemical warfare such as sarin. The effects /manifestations produced by these compounds are exaggeration of cholinergic effects - Muscarinic, nicotinic and central (Brunwald et al-2001)[4].

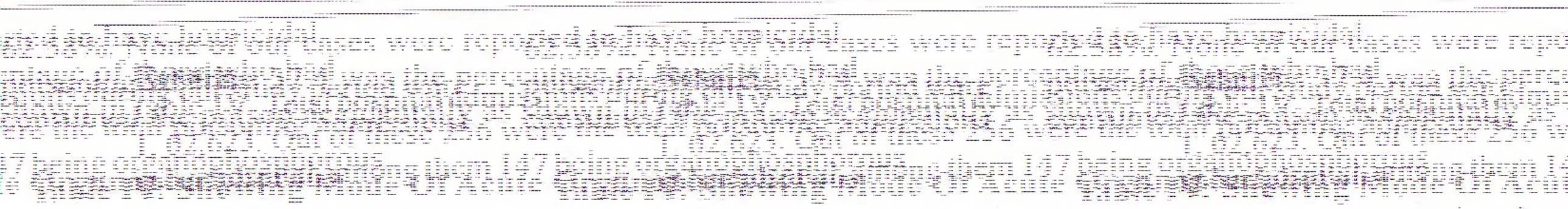
Materials & Methods:

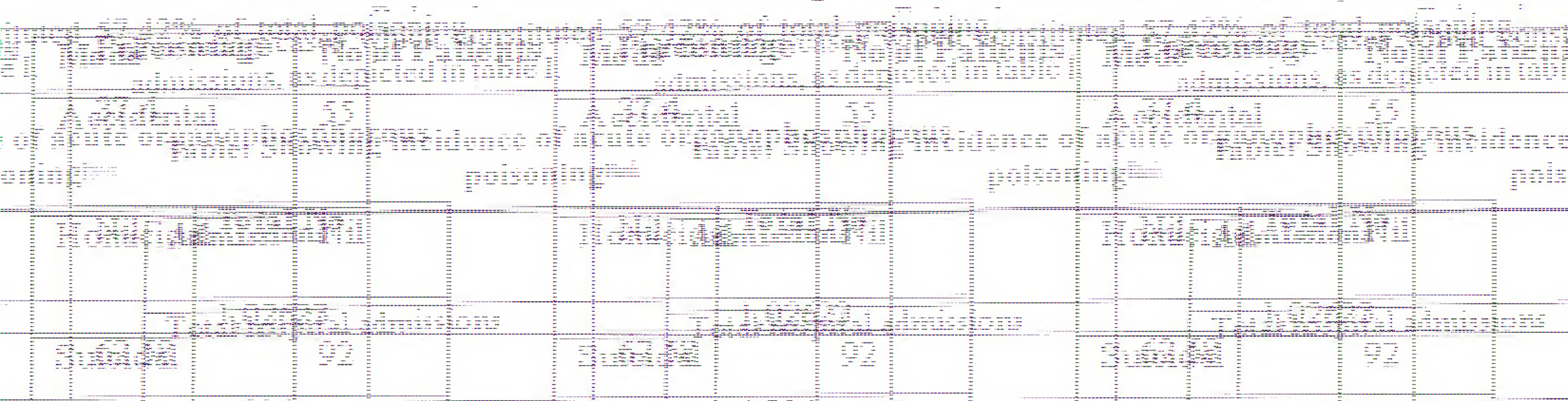
This Hospital based study in which all the patients admitted to department of Anaesthesiology and Critical Care unit, accident and emergency and department of Neurology with provisional diagnosis of poisoning, clinical epidemiological profile of only those patients established to have organophosphorous poisoning was studied prospectively for a period of two years.

This hospital-based study has been undertaken with the interest that many varieties of organophosphosphorous poisons are available and consumption of these poisons is resulting in regular hospital admissions. Careful and detailed history and thorough examination of these patients is really diagnostic and equally important as institution of specific therapy. The patients' demographic profile was screened for diagnosis of organophosphorous poisoning by (I) History (II) Examination and (III) Investigations. The clinico epidemiological profile of acute organophesphorus poisoning was established in relation to incidence, Age & Sex distribution Rural & Urban distribution, Mode of poisoning, Route & frequency of signs and symptoms of organophosphorus poisoning was established.

Key Words: Prospective study, acute organophosphorous poisoning, cholinergic effects, atropinisation, pralidoxime, ventilatory support, hemoperfusion.

epidemiology epidemiology epidemiology





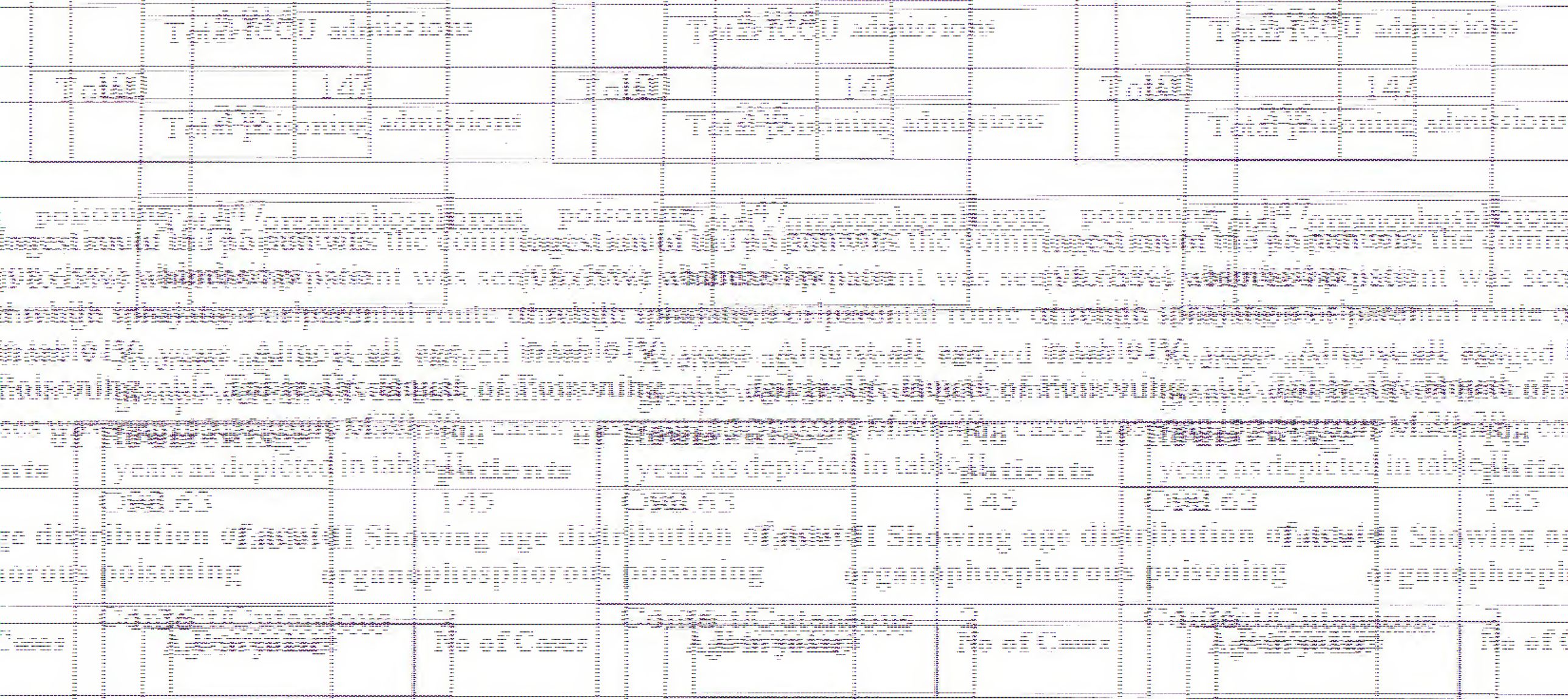


Table-VI: Signs and Symptoms of Acute Organophosphorous Poisoning

Signs/symptoms	No of Cases	Percentage
A) General examination		
Sweating	36	24.48
Salivation	92	62.58
B) CVS		
Tachycardia (>100/min)	69	46.93
Bradycardia (<60/min)	13	8.8
C) Respiratory system		
Tachypnoea (>30/min)	51	34.93
Rhonchi & crepts	63	42.85
Hypoventilation	32	21.76
D) GIT		
Vomiting	57	38.77
Diarrhoea	19	12.92
E) CNS		
Disturbed level of consciousness	86	58.50
Miosis	122	82.99
Fasciculation's	71	48.29

Discussion:

The results of our study are consistent with the reviewed study. A total number of 256 cases of poisoning were admitted in the hospital during our study period which constituted 0.24% of total hospital admissions. Out of total 256 poisoning cases 147 were of organophosphorous poisoning which constituted 57.42% of total poisoning admissions.

R.S.Sexena et al (1989)[1] in a retrospective study of organophosphorous poisoning cases observed that over all poisoning admissions in their hospital constituted 5.22% of total intensive care unit admissions which is slightly higher than the percentage we observed in our study. The organophosphorous poisoning cases constituted only 27.85% of the total number of poisoning cases in their study which in contrast to our observation.

Bardin PG et al (1987)[5] observed in their study that organophosphorous poisoning was the second most commonest reason for admission to intensive care unit in their hospital.

Hayes MMM et al (1987)[6] and R.S. Saxena et al (1989)[1] also observed a rising incidence of organophosphorous poisoning cases over the years. Their observations coincide with our observations.

Age groups involved were different. The youngest patient in our study was a nine months old child with accidental poisoning due to contact absorption which occurred when the child was kept near an open organophosphorous insecticide heap while the mother was working in the field and the oldest patient was 50 years old man. The majority of our cases 59(40.13%) presented in the age group of 20-29 years i.e. 3rd decade, 51(34.69%)cases were in 2nd decade, 16(10.89%) cases were in the 4th decade, 11(7.48%) cases were in the 5th decade, 8(5.44%) cases were in the first decade and only 2(1.36%) cases were in the 6th decade.

Hayes MMM et al (1978)[6] also observed that the highest incidence was in the 3rd decade which is in conformity with our findings. Also our results go in accordance with the results of J.Sunder Ram et al (1991)[7].

Both Sexes were involved and 87(59.18%) cases were females and 60(40.87%) were males in our study with a female to male ration of 1:4:1.

Our results are in confirmity with the results of J.Sunder Ram et al (1991)[7], A.E.Delikan et al (1984)[8] in a series found much higher (88%) incidence of organophosphorous poisoning in females.

This higher incidence of poisoning in females in attributed to different reasons like divorces, windows social problems like unwanted pregnancies and other different kinds of psychological trauma.

Mode of poisoning under study was seen and observations made were that 92(62.58%)cases were suicidal whereas only 55(37.4%) cases were accidental. These results are in similarity with the results of Thomas Chang-Yoa Tsoa et al (1990)[9] and Bardin PG et al (1987)[5]. The former found the incidence of suiciders upto a mark of 65% whereas the suicide rate in the laters series was 61%

Different Routes of poisoning were used by patients 145(98.63%) cases in our series had history of oral intake of the poison whereas two patients had history of contact poisoning. There was no case with history of inhalation or parental administration of the drug.

Delikan AE et al (1984)[8] also observed oral route to be the commonest (98%) route of poisoning which is in confirmity with our results.

Clinical manifestations of organophosphorous poisoning is basically due to accumulation of acetylcholine resulting from inactivation of cholinesterase by organophosphorous compounds Margarett wood (1990)[10] & Braenwald et al (2001)[4].

In our series sweating was found in 24.48% cases, salivation in 62.58% tachycardia in 46.93%, bradycardia in 8.8%, vomiting in 38.77%, diarrhoea in 12.92% tachypnoea in 34.93%, ronchi and crepitating in 42.85%, hyperventilation in 21.76%, disturbed level of consciousness in 58.50% miosis in 82.99% and fasciculation's in 48.29% cases.

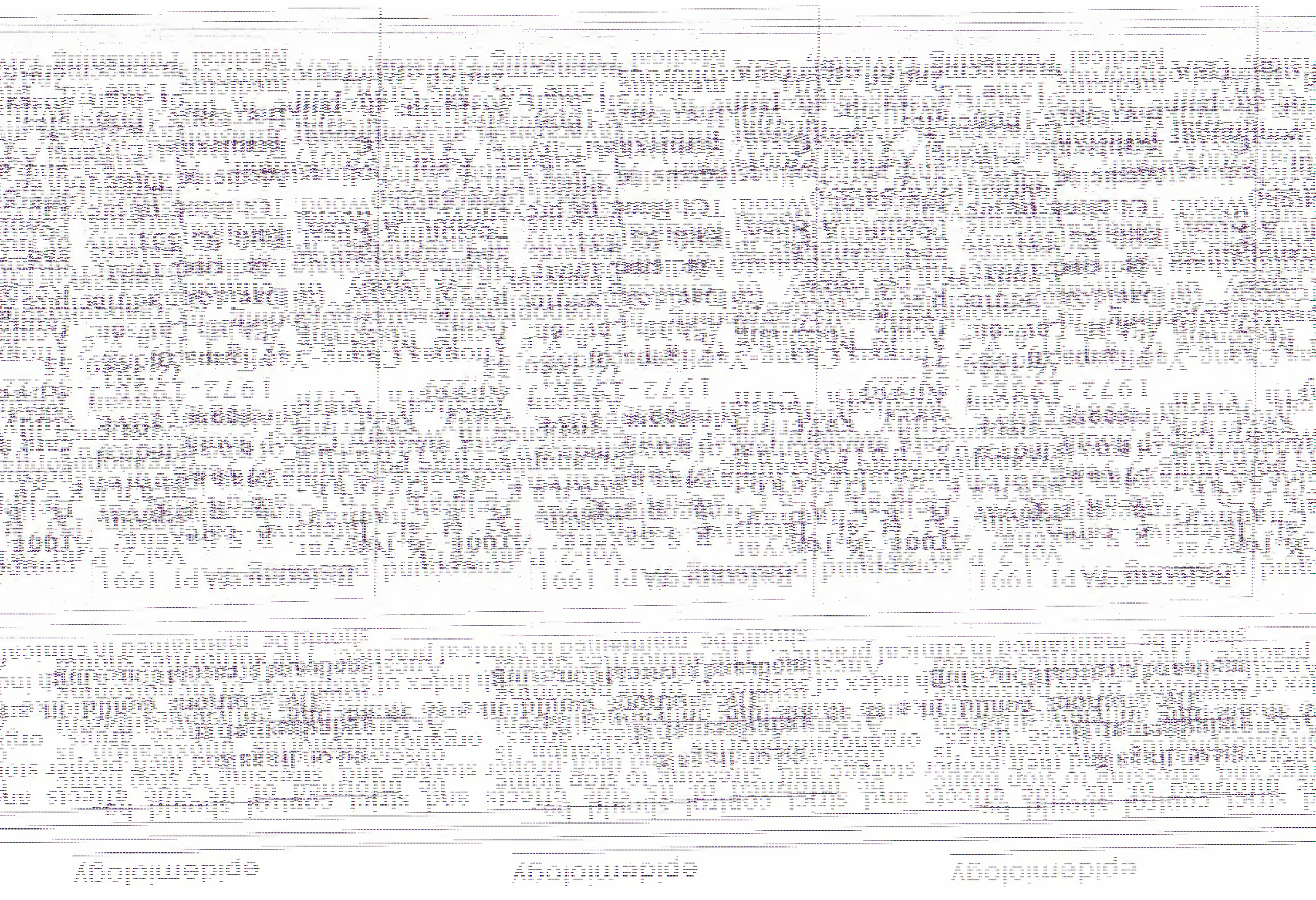
Our observations are in similarity with the observations of Bardin PG et al (1987)[5] and Hayes MMM et al (1978)[6].

Conclusion

A steady increase in the number of cases due to poisoning were seen over a period of study in which organophosphorus poisoning was number first which constituted about 57.42% of total poisoning admission in our hospital. Maximum numbers of patients were in the age group of 2nd & 3rd decade of life. Females constituted maximum number of cases (59.18%) with female to male ratio of 1.45:1. The poisoning was suicidal in 62.58% and accidental in 37.4% of cases. Commonest route of consumption was oral 98.63%. Maximum numbers of cases were from rural areas to tune of 80.27%. The poisoning produced varied clinical manifestations which were due to exaggeration of cholinergic effects at varied sites.

Recommendations

To decrease the chances of poisoning efforts should be directed towards preventive measures which can be accomplished by creating awareness among public about dangers associated with particular poison & toxic effects of



Trends in Antenatal Care Utilization in Block R.S. Pura of District Jammu.

Raina SK; Mengi Vijay; Singh Gurdeep

Abstract
The findings of a field based cross section survey covering a period of one year (July 2003 July 2004) to access the utilization pattern of antenatal cone services in a block of Jammu district one presented in this paper. Women with children less than one year were part of the study.

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Introduction

Children are the most vulnerable and women the most burdened members of the soceity. Their health is closely intertwined. Over half a million women in developing countries die each year from causes related to pregnancy and child birth. Leaving atleast one million children motherless. Whereas in Europe the MMR is 6/00,000 live birth, in parts of Asia and Africa it may raech 1,000/100,000 live births[1]. In the poorest countries the risk of dying from preganancy or childbirth is 200 times higher than in developed countries[1]. Millions of women who are not properly cared for in pregnancy and child birth are in constant state of ill health.

Much of the shortcomings in MCH in developing world can be reduced by attention to antenatal care. For each additional 00-kcals/day digested throughout pregnancy, the birth weight will incrase by about 100 grams[2].

The existing literature on the use of MCH services has focused on the effectiveness of various family planning methods, while studies pertaining to the use of services for maternal care are rare.

Material and Methods

Study Area: The study was carried out in the block R.S Pura, Rural Catchment area of Government Medical College, Jammu. There are 76 villages and town in the block with an estimated population of 1,79,636[3]. The block is located in the southwest of Jammu city adjacent to Indo-Pak border with a total area of 273 sqkm and average density of 658 per sqkm.

Sample Population: The study population comprised of 375 mothers. Out of these 300 mothers were selected independently from 20different villages in rural area with each village contributing 5 mothers were picked up from 5 wards of R.S. Pura town representing the urban area.

The sample population comprises of pregnant mothers who were eligible for immunization and antenatal care one year prior to the date of survey. Thus sample population for maternal care services comprised of mothers with children less than one year (12 completed months) of age.

Sampling methodology: The methodology consisted of a stratified two stages design in accordance with IRMS (ICMR) Delhi methodology[4]. The stratification was according to population size of the village in rural area. The village was primary sampling unit and the mother as the secondary sampling unit. 176 villages of block R. S. Pura were stratified according to their population into four different strata. Five villages were selected from each stratum by simple random technique. Thus the total number of villages taken was 20.

Selection of mother from each village: Fifteen mothers having children less than one year (12 completed months)at the time of study were picked up independent of each other.

Thus three hundred mothers were picked up from rural area. The village selected was mapped and different direction identified. One direction was selected randomly and house to survey conducted till 15 desired mothers were recorded.

Selection of mothers from each ward: R.S Pura town of block R.S.Pura was taken as urban area for this study. Out of the total 12 wards of the town , 5 wards were selected randomly .The selected wards were identified with the help of an identification number. 15 mothers with children's of less than 1 year age (12 completed months) were picked up from each ward independent of each other house to house survey as was done in the rural area. Thus the total number of mothers picked up from the urban area was 75. The number of mothers was fixed as 75 keeping in view of the rural- urban ratio of 80:20 in j& k[5].

Full antenatal care means 3 antenatal check ups, two TT/booster and two doses of IFA tablets.

Key words: Antenatal care, women, child, utilization

rural health
rural health

Discussion

Discussion
Discussion

References:

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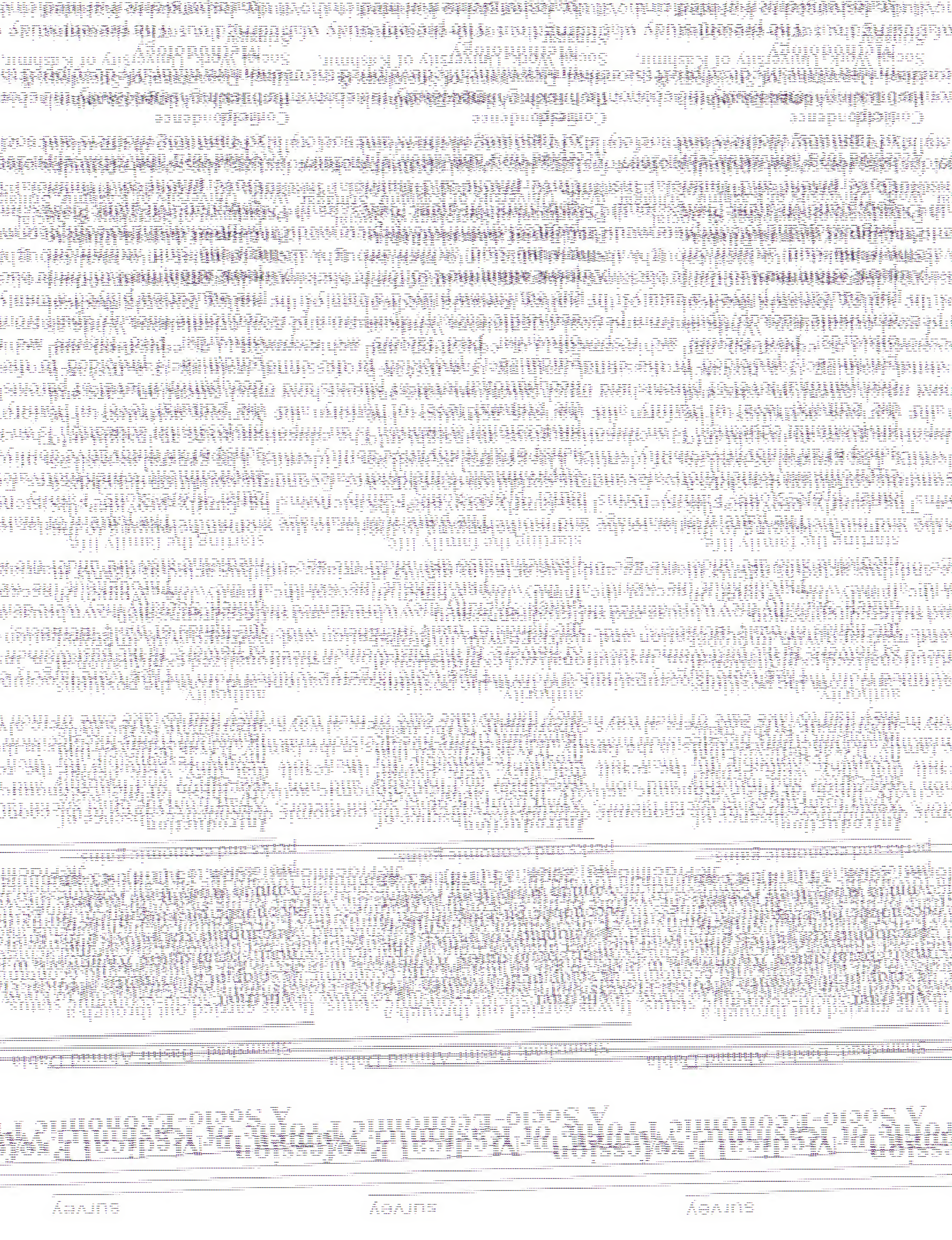

made questionwise which led to the explanation and interpretation of the responses and then percentages were calculated and inferences drawn accordingly.

Observations & Discussion

The majority i.e. 74.00 percent of the women medics in the simple of the study were married and only 26.00 percent women medics were unmarried. As far as the age of women medics is concerned, 50.00 percent belong to the age group of 36-45 years followed by 40.00 percent age group of 25-35 years. The lowest percentage of women medics i.e. only 1.00 percent belonged to age group of 46 and above years. The majority i.e. 59.00 percent of women medics belonged to nuclear families and 41.00 percent belonged to joint families. The women medics enjoyed happy family life and spent time with their family members. The family obligations were given due importance but not at the cost of their professional responsibilities. The majority of women medics i.e. 80.50 percent preferred nuclear families with small number of children while there are only 19.50 percent of women medics with large number of children in their families. The majority of women kept balance between two roles and therefore devoted attention towards their professional role. As for as economic position of women medics is concerned, 58.00 percent earned an income of Rs. Upto 15000 per month, 39.50 percent women medics earned an income of Rs. 15001-30000 per month. The lowest percentage i.e. 2.50 percent respondents earned a self-income of above Rs. 30,000 per month. Thus the sound and higher income of women medics has created a change in the economic power structure of the family. The women medics have full authority and independence in spending their income for the purpose of getting higher medical degrees. The income status of women medics' family play an important role in moulding their careers. About 64.50 percent women medics total family earnings are Rs. 30001-50000 per month, followed by 27.00 percent with upto Rs. 30,000 per month. The total family income of 8.50 percent women medics were above Rs. 50,000 per month. Thus the majority of women medics got full fledged financial assistance of family for further studies. As far as the professional educational background of women medics is concerned, out of total sample, 60.00 percent were with basic medical degrees i.e. MBBS degree while 40.00 percent women medics were with Postgraduate/Diploma degrees. Only 33.00 percent were the permanent job holders, 14.00 percent were working on contractual or adhoc basis and the majority of women medics i.e. 53.00 percent were without any permanent job or were working in valley's private health and medical establishments on very small perks. The women medics prefer the medical profession due to family encouragement and personal interest in the medical studies. They used the valuable learning experiences earned through the medical specializations for the welfare of diseased people. As far as the occupational status of the parents (father and mother) and husbands of the women medics was concerned, among fathers, 27.50 percent are government employees, 24.50 percent were business executives, 45.50 percent were retired employees, 1.50 percent were doctors and 1.00 percent were bank and media professionals. Thus the majority of women medics' parents earn and were highly qualified thereby produced an influence on their girl children. Among mothers, 32.50 percent were in government service, 55.00 percent were housewives, 12.00 percent were retired employees and 0.50 percent in doctor's profession. Thus majority of mothers of women medics were housewives and all of them were literate and exercised a strong influence on the career development of their children by their attitudes. Among husbands, 49.50 percent were in medical profession, 15.00 percent were engineers, 7.50 percent were business executives and only 2.00 percent were bank professionals. Thus majority of women medics' husbands were in the same profession thereby understand the duty schedules and patterns and help their wives in performing the professional role without any hindrance. The women medics got full support from their husbands for further continuation of the medical studies. The economy and education of parents and later husbands were the two important determinants that encourage and moulded Kashmiri women into medical profession. Besides, women's own interest, brilliant academic records, aspirations for social mobility and feeling of obligation to oneself or to society to use one's potential, expertise and skills were also important. As far as experience of women medics was concerned 78.50 percent worked inside the state, 5.00 percent worked outside the state, 9.50 got experience outside the country and 7.00 percent are with very little experience inside the state. Thus majority of women medics worked inside the state, showed interest in serving and providing the treatment to the Kashmiri Society. Besides, the women medics were more committed to their professional role and knew about their responsibilities fully. As far as demographic background of women medics was concerned, 78.50 percent belonged to urban areas, 19.50 percent belonged to rural area and only lowest proportion i.e. 2.00 percent were migratory. Thus majority of women medics live in urban areas and were fully

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S. No.	Marital Status	No. of Respondents	Total Percentage
1)	Married	148	74.00
2)	Unmarried	52	26.00
3)	Divorced	00	00.00
4)	Separated	00	00.00
Total		**200**	**100.00**

S. No.	Family Structure	No. of Respondents	Total Percentage
1)	Nuclear	118	59.00
2)	Joint	82	41.00
	Total	**200**	**100.00**

S. No.	Income Status (Self) (Rs. Per Month)	No. of Respondents	Total Percentage
1)	Upto 15,000	116	58.00
2)	15,001 – 30,000	79	39.50
3)	Above 30,000	05	2.50
Total		**200**	**100.00**

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Medical training

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communication and IT skills

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Refugee doctors

Refugee doctors

Refugee doctors

Conclusion

Conclusion

Conclusion

To Whom It May Concern

An unfortunate incident of plagiarism has recently come to light. The author's work has been published under commentary section of our Journal, JK-Practitioner in the year 2007.

Full details of the published article are:-

Suhail Afzal, Asif Sultan, Mohd. Iqbal, Shabir Dhar. Lateral Decubitus positions in Spinal Surgery. JK-Practitioner 2007;14(2):110-112.

This article is a straight lift from the article published earlier in the Journal of Orthopedics in 2005 by different authors.

As a fallow up action all articles by **Dr. Suhail Afzal** appearing in **JK-Practitioner** have been withdrawn fourthwith. Further the author has been blacklisted and no article by him will ever be published in **JK-Practitioner** in future.

As regards the policy of the Journal in such cases the responsibility of the article solely rests with the correspondence author in respect of contents of the manuscript. (**Dr. Suhail** has been the main (first) and corresponding author of this article).

The co-autors in these manucripts have been found not to have contributed to the duplicity of the manuscript. However they are advised to desist from any association with **Dr. Suhail Afzal** in future work.

Editor

Congratulations

The editorial board congratulates:

- Prof. Shahida Mir on assuming charge as Principal Govt. Medical College Srinagar on the superannuation of Dr. M. A. Shah on 28-02-01
- Dr. Muzaffar Ahmad Director Health Services for being awarded the prestigious B C Roy award 2008 on Doctor's day at New Delhi for his excellent contribution as Director Health Services Kashmir.
- Prof. G M Malik for being selected to receive "INTERNATIONAL ACHIEVER'S" for Health excellence the award presentation ceremony shall be held during the 18th International Achievers summit on 23rd March 2009 in New Delhi

Book Review

Epidemiology and Management for Health Care for All (3rd Edition). Edited by: P.V. Sathe, Vora Medical Publication, Mumbai-400 003, India. 2009 (revised edition), ISBN 81-8406-010-6, PP, Rs. 350/-

New editions of this book has been updated & some irrelevant topics have been dropped in this edition. This book I find very informative & helpful for all medical professionals dealing with practice of medicine, planning & administration.

The author of the book has shared his vast experience based on problems faced by our doctors working in this subcontinent & has given us ideas about various measures to be taken in this country to tackle/plan measures to prevent various diseases as well as how to improve our health care system & grown our Medical Tourism to attract NRI's for treatment at affordable Price.

As professor of Medicine I strongly recommend this book to all Medical students, Pg's Medical Officers & Administrators of both Govt. & Non Govt. Organizations. They will definitely like it. Cost is affordable. I hope future edition will have coloured title pages & diagrams.

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Supplement Number 2 (2008)

Focus on Hospital Administration

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From the Editor

This is the second supplement published with JK Practitioner. The first dealing with post Traumatic Stress Disorders came as a separate publication in 2006. It is our endour to give space at length to various specialized issues, not possible in a general medical journal. Hospital administration has acquired new dimensions in total health care. No longer can hospital organize it self in an efficient way if it doesn't have a skilled manager. One of the American philanthropist has rightly said " I am ready to pay any amount under the sun to the skilled manager as he will be managing and hiring the best brains for the organization." The focus of the present supplement is to present some of the issues concerning this important speciality.

G. M. Malik

Dr. Reyaz A Rengrez
Supplement Editor

Primary Education at D.A.V. School Srinagar, a graduate of Islamia College of Science & Commerce (1974-75), gained entrance on merit for M.B.B.S and completed the same in 1981-82, served in Republic of Iran for some time before joining SKIMS Srinagar as junior resident. Completed M.D. Hospital Administration in 2000 from the Institute and appointed to faculty in 2005.

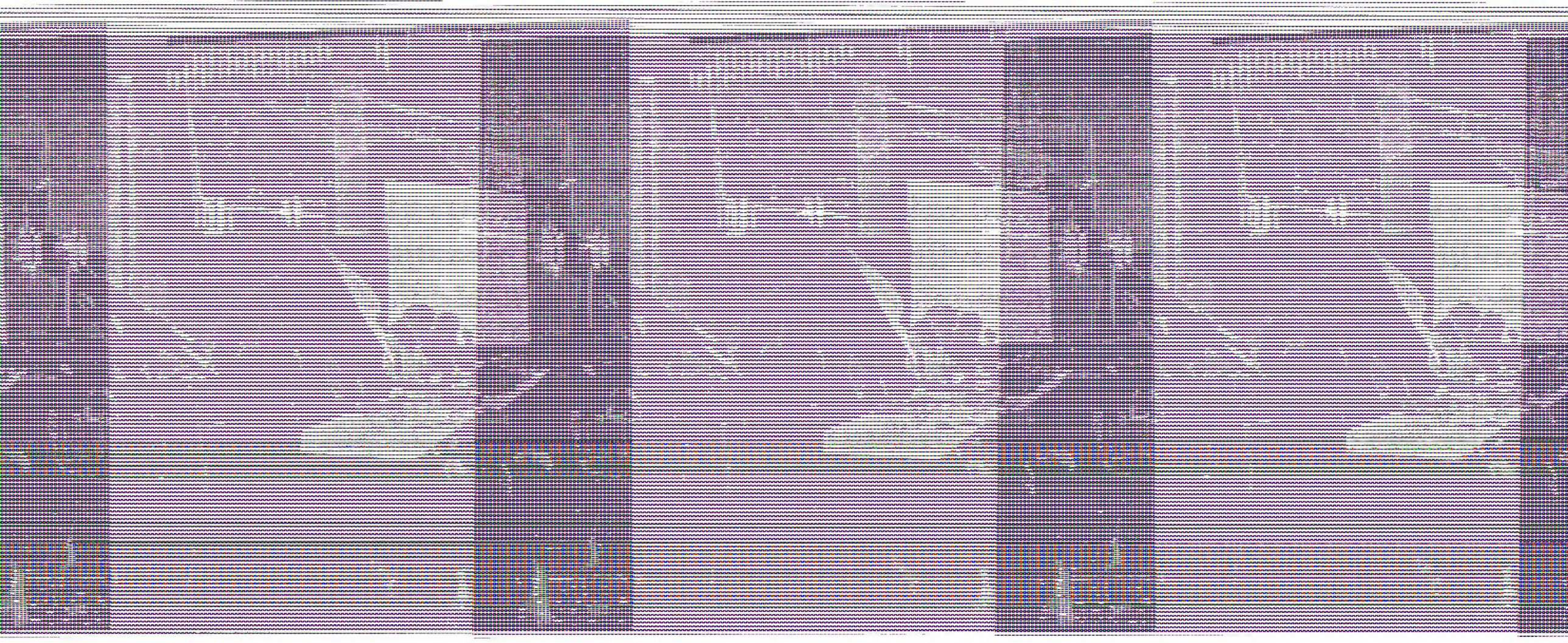
Has been a keen researcher and an excellent manager. Was organizing secretary of a recently held National Conference on "Challenges in Hospital Administration" which was held in Srinagar from 7-9-September 2007, the deliberations of this conference form some of the substance of this supplement.

Dr. Riyaz A. Rangrez was awarded certificate of merit for showing strong leadership qualities and was presented with the award of excellence by the Chief Minister of J& K State, in the silver jubilee year of SKIMS in 2007.

This supplement on Hospital Administration has been possible by the generous grant from some business houses of the state of J&K.

The untiring efforts of each & every member of the Department of the Hospital Administration at SKIMS in assembling the research papers has been incredible.

Introduction
Introduction



establish Satellite hospitals in these areas.

2. The public has become more health conscious and has in general begun to believe that the health and health care constitute a basic right rather than a privilege for a chosen few has to be kept in mind. This demands provision of more effective patient care and patient satisfaction. Thus requiring planning and organization of medical services keeping focus on the patient needs rather than the professional needs and providing quality health care by means of coordinated health services at all levels e.g. local, State and national levels.
3. Spiraling Health care costs and wide variations in costs among the various health care providers is a challenge which needs our attention. It requires:

✓ Re-looking at financing of health care
✓ Allocation of budget keeping in view that spending on health is an investment
✓ Strengthening and subsidizing the health insurance Schemes for low socio economic groups.
✓ Strengthening of ambulatory care to reduce the hospital in-patient stay in order to make use of our scarce bed resource (currently 1.3 per thousand populations) judiciously and economically. The coming up of corporate hospitals in the country is a welcome change but when we see the payments to be made to the hospitals by the beneficiaries, it varies among various corporate hospitals. This needs to be looked into by the authorities. In order to achieve the health for all by 2012 and increase the bed ratio from current level of 1.3/1000 to 5/1000 populations by 2012, the participation of the private sector including private health insurance at all levels of health care primary, secondary and tertiary is a welcome change. But without suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments and medical institutions will prove counter productive. Recently Federation of Indian Chamber of Commerce and Industries (FICI) suggested three public private partnership models for primary, secondary health care, a net work of diagnostic centers, capital expenditure sharing, equity sharing and premises on lease models. These need consideration by the policy makers and planners.
✓ Accreditation of health care institutions to have quality services, education and training.

4. Administration of health care organizations with competent and trained hospital and health care administrators is a matter of concern and need of time and requires our immediate attention. We have not been able to find ways and means to recruit and retain the necessary career professionals who could broaden the concern to human services and bring in competence, continuity and consistency in the operations of the health care institutions.
5. Introduction of the training programs for hospital quality Managers is the need of the time and our premier institutions in the country should take a lead in starting such training programs.
6. Minimal statutory norms with constant reviewing for the development of Doctors, Nurses, Technologists, on need basis in medical institutions need to be introduced urgently under provisions of the Indian Medical Council and Indian Nursing Council Acts.
7. Maintenance and optimum utilization of Equipment and Machinery: This remains a challenge as well as a serious concern. The various studies and the surveys conducted by the department of Electronics Government of India have reported that on an average 25 to 30 percent of equipment and machinery in the Indian hospitals is non functional for want of technical expertise to use or maintain. Inadequate maintenance, repair and mishandling are resulting in the reduced life time of equipment. Lack of expertise in choosing appropriate equipment, non availability of spares and accessories and unfavorable purchasing contracts are some of the main reasons for under utilization and reduced life time of the equipments in the hospitals. This is a challenge which needs to be addressed by all concerned.
8. Information technology has certainly enhanced the access to health care services to patients but at the same time has greatly facilitated the flow of patient related information. The creation and use of health information has been a matter of great concern to the providers of the health care service and needs our immediate attention. However care needs to be taken that the information should be precise, timely, appropriate, qualitatively and quantitatively adequate and with the right person for its optimum use and avoid misuse.
9. Medical profession is considered as noble profession because it helps in preserving life. We believe life is "God given". Thus a doctor figures in the scheme of God as he stands to carry out His command. A patient generally approaches a doctor/hospital based on his/its reputation. Expectations of a patient are two fold: Doctors and hospitals are expected to provide medical treatment with all knowledge and skill at their command and secondly they will not do anything to harm the patient in any manner either because of their negligence or careless or reckless attitude of

Marching Ahead

Hospital Administration has come a long way to establish itself first in Health services & now in Teaching hospitals. Though initially the subject did not go well with medical doctors, now there is a preference for it. Since mid seventies need was felt to have Managers for running the Health Services in general & Hospitals/Medical Institutions in particular. This was a global trend & India was no exception to it.

In the state of Jammu & Kashmir, Department of Hospital Administration was established with the coming up of Institute of Medical Sciences(SKIMS), Srinagar. This was soon followed by the creation of the faculty for Hospital Administration & in early nineties post-graduation course (MD) was started. SKIMS, as such, is one of the five such centres in the country to conduct MD in Hospital Administration recognized by Medical Council of India, others being AIIMS, AFMC Pune, Nizam Institute Hyderabad & Kasturba Medical College Manipal. In addition, State has at the moment more than a dozen trained Hospital Administrators at important managerial positions. The professional streak in them has naturally led them to conduct research on the various aspects of Health Administration.

An opportunity has been provided by the Editorial Management of JK Practitioner to assemble the research articles in Hospital Administration for publication. All the articles are original research, touching the very core of Management, particularly at these times, when Hospital Executive is very much in the focus of the public, authorities, politicians & even pro-active judiciary. So the research is the need of the hour in the backdrop of the heat of the moment.

The papers submitted, like patient satisfaction has the relevance in the context of the behaviour of the providers, expectation of service users, together with the supportive infrastructure to identify the weak as well as strong points in the establishment.

Research touching Waste Management is a burning issue at present. All researches should hopefully help refining & fine-tuning the system of waste management in the hospitals to the expectations of general public & authorities.

Topic on head injuries is relevant as the State is passing through a violent phase further compounded by increased automation, industrialization, together with heavy movement of people using means of fast transport.

Teaching hospitals have Intensive Care Units & they are under severe strain at the moment with changing profile of diseases. Some authors have done an excellent job to highlight the work load in Intensive Care areas.

Any health care facility should have some standard for provision of health care services. Every care provider in the hospital should be aware of it & his perceptions and awareness of quality should help in creating an image for the hospital. Authors have made a good attempt to conduct a research in this field, otherwise very touchy & at the same time forbidden subject.

Hospital Management has a moral obligation to provide clean linen to the hospital, both from aesthetic and environmental point of view. Research in this vital Support service has provided timely input to Hospital Administration.

It was very difficult to accommodate all the research papers in one go but this should not dampen their academic enthusiasm. More fine-tuning, more refinement & a more scientific approach, place for them is assured.

Above all, the stream of Hospital Administration has come out of infancy & is on its feet, right towards adulthood.

Dr. Reyaz A. Rangrez (Shah)
Supplement Editor
BSC; MBBS; MD; MAHA
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organizational change agents.
-Identify knowledge and skills which help project managers perform successfully.
-Describe performance measures that apply to project management.
-Understand the need for senior management support.

Project work

-Submission of a dissertation in partial fulfillment of postgraduate diploma.
-Dissertation shall be relevant to the quality management in healthcare and medical care services.
-Study to follow FOCUS approach.

FOCUS approach

-F = Find a process to improve
-O = Organize a team that knows the process.
-C = Clarify current knowledge of process
-U = Understand causes of process variation
-S = select the best process improvement for recommendation

Eligibility

Preferably doctors ,dentists and nursing professionals / Pharmacists working in supervisory capacity and having minimum graduation in their respective disciplines and having aptitude for quality.

Course details

Orientation to program and the role and responsibilities of QM (quality Managers) in hospital.
The components of the course are:

1. Program philosophy, Mission and vision
2. Policies and procedures.
3. Roles, responsibilities and accountabilities of quality Managers.
4. Quality Management tools.
5. Leadership and use of teams.
6. Measurement and assessment.
7. Report writing / and follow up.

Quality planning and administration.

Components.

1. Organizational analysis.
2. Concepts of C Q I and T Q M.
3. Concepts of surveys, surveillance and operational audits.
4. Models of strategic and operational planning.
5. Concepts of planning model.
6. Concept of quality function deployments (QFD). on planning scheme for timing and resource allocation.

Health care systems and quality management theory.

Components:

1. concepts of system/ sub system
2. Globalization of health care.
3. Health care systems including India.
4. Financing of health care, various models.
5. Health care standards and accreditation.
6. Linkage between health care standards and accreditation.

Information system

Skill development in:-

01. Identifying / relevant project data locating
02. Designing data collection instruments
03. Selecting appropriate data display
04. Building spread sheets/ a data base
05. Using word processing.

Management and leadership components

01. Theory of leadership
02. Models of management
03. Team building and team leadership
04. Leadership in quality improvement
05. Management of the quality process

Managerial statistics

Components :-

01. Quantitative and random variability
02. variation
03. Central Tendency
04. Dispersion range and standard deviation
05. Frequency distribution, normal distribution measures of central tendency for grouped data.
06. Computers and software- SSPS

Decision making

Components :-

01. Decision models including decisions under certainty and uncertainty
02. Process improvement tolls
03. Identifying key information needs.
04. Collecting / displaying / analyzing data
05. Information management

Research and project management

Components :-

01. Identifying project data
02. designing data collection instruments
03. Data analysis and presentation
04. Writing research reports
05. Writing effective recommendation
06. Follow-up

Organization Development components

01. Communication skills
02. Group dynamics
03. Change theory
04. Non statistical quality management tools
05. Human Resource development
    I) Education and Training
        a) need analysis
        b) Evaluating, coaching and facilitating group process

viewpoint viewpoint viewpoint

Manifestation of Chaotic Behavior in Cardiac Pacemaker Cells

Author Author Author

Abstract Abstract Abstract

Received 2000; Accepted 2000; Published 2000

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Acknowledgments Acknowledgments Acknowledgments

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Table-2: Reported/Perceived level of knowledge about quality management philosophies & techniques

	Faculty		Specialists		Residents		Hosp. Adm. Upper level		Hosp. Adm. Lower level		Nurs. Adm.		Nursing Supervisors		Staff Nurses	
	GMC n=66	SKIMS n=67	GMC n=54	SKIMS n=57	GMC n=189	SKIMS n=95	GMC n=9	SKIMS n=3	GMC n=10	SKIMS n=12	GMC n=6	SKIMS n=6	GMC n=25	SKIMS n=26	GMC n=186	SKIMS n=171
P	2 (3.03)	3 (4.47)	—	4 (7.01)	43 (22.75)	20 (21.05)	—	—	—	—	—	—	4 (16.0)	2 (7.69)	42 (22.58)	30 (17.54)
F	25 (37.87)	29 (43.28)	29 (53.70)	34 (59.64)	120 (63.49)	48 (50.52)	4 (44.44)	—	6 (60.0)	7 (58.33)	5 (83.33)	1 (16.66)	12 (48..0)	11 (42.30)	109 (58.60)	102 (59.64)
G	39 (59.09)	35 (52.23)	25 (46.29)	19 (33.33)	26 (13.75)	27 (28.42)	5 (55.55)	3 (100)	4 (40.0)	5 (41.66)	1 (16.66)	5 (83.33)	9 (36.0)	13 (50.0)	35 (18.81)	39 (22.80)

P=Poor F=Fair G=Good — n(%)

In order to validate the claims and find the level of knowledge about quality, analysis revealed that contrary to claims, 3.5% test population in general had knowledge of concepts, philosophies & techniques.

About definitions and meaning of quality on awareness scale across 4 statements (Table-3 J) revealed that Faculty is better aware (GMC 74-83%; SKIMS 79-91%) than Specialists (GMC 70-81%; SKIMS 74-76%) who in turn are better aware than Residents (GMC 58-72%; SKIMS 64-68%). Among Hospital Administrators general awareness in SKIMS (upper level 100%; lower level 92-100%) was found more than that in GMC (upper level 78-100%; lower level 70-90%). Comparatively lower general awareness was found in Nursing Personnel in GMC- Nursing Administrators (33-50%), Nursing Supervisors (44-60%) & Staff Nurses (39-47%) than other groups in GMC & SKIMS as well as their counterparts in SKIMS- Nursing Supervisors (58-73%) & Staff Nurses (55-66%). All categories in SKIMS rated better than their counterparts in GMC.

Analysis of 3 statements (Table-3 K) that actually test the Specific knowledge and concepts of quality philosophies & management techniques revealed that Hospital Administrators from SKIMS (Upper level 100%; Lower level 75%) have highest level of awareness as compared to 33% Upper level Hospital Administrators from GMC & 0-33% Nursing Administrators of SKIMS. Residents, Nursing Supervisors & Staff Nurses both in GMC & SKIMS as well as Lower level Hospital Administrators & Nursing Administrators of GMC lack in specific knowledge-based quality awareness. There was no appreciable difference in knowledge about quality techniques between Faculty (GMC 0-6%; SKIMS 0-10%) & Specialists (GMC 0-6%; SKIMS 0-7%).

Level of perception of quality among Clinicians, Hospital Administrators & Nursing Personnel was studied using 6 negative phrases (Table-3 L). Amongst Clinicians of GMC, Specialists (39-91%) revealed a higher positive perception as compared to Faculty (36-86%) & Residents (26-62%). Among Clinicians in SKIMS, perception levels were slightly improved - Faculty 45-97%, Specialists 46-81% & Residents 35-77%. In GMC, positive perception was found in 56-100% Upper level & 30-100% Lower level Hospital Administrators. In SKIMS, 100% Upper level & 75-83% Lower level Hospital Administrators had positive perceptions. Nursing Administrators (50-100%); Nursing Supervisors (35-77%); & Staff Nurses (23-63%) of SKIMS had slightly higher positive perceptions than their GMC counterparts 17-84%, 24-72% & 28-57% respectively.

Simultaneously direct approach adopted through responses across 5 positive phrases (Table-3 M) about perception of quality showed that Faculty (GMC 55-97%; SKIMS 61-100%); Hospital Administrators (Upper level GMC 67-100%; SKIMS 100% & Lower level GMC 50-100%; SKIMS 83-100%); Nursing Administrators (GMC 33-100%; SKIMS 100%) rated higher & those from SKIMS rated better. Specialists (GMC 44-93%; SKIMS 47-93%) & Nursing Supervisors (54-88%) of SKIMS rated next. Residents from GMC (40-82%) & SKIMS (40-80%) had identical rating. Staff Nurses (GMC 30-77%; SKIMS 37-73%) & Nursing Supervisors (36-76%) of GMC rated lowest among all groups.

Analysis of two statements (Table-3 N) to know about attitude of respondents towards learning more about & their willingness to take active part in implementing quality improvement programme revealed that Faculty (GMC 94-97%; SKIMS 97-100%) were more positive in their attitude towards quality than Specialists (GMC 93-96%, SKIMS 93%) while Residents (GMC 83-84%; SKIMS 86-88%) comparatively had lower rating. Hospital

by the functional orientation of the area. This by itself could be a dominant influencing factor on these results about differences in the employees of SKIMS and GMC regarding perception of quality.

It is collective attitude of institutional personnel that determines the degree of quality exhibited by the institution. Hospital Administrators were a little ahead of Clinicians in their attitude towards quality though they did not differ much. The Nursing Personnel had a lower rating for their attitudinal behaviour.

The employees' perception depends upon their length of time with the organization,(13) therefore has a strong relationship with the age of employees. The faculty, specialists, Hospital Administrators & Nursing Administrators were having higher levels of positive attitude towards quality while Residents, Nursing Supervisors & Staff Nurses having comparatively less age, experience, qualification(13) had concomitantly lower levels of positive attitude.

Ultimately no amount of law, regulations, policies, procedures or ethical principles, guidelines or codes will directly control the quality of care received by the patients. Rather the individual morality of health care professional and level of the responsibility that the professional is willing to assume, will circumscribe the quality[14].

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Study population

The questionnaire was given to patients admitted in various wards of SKIMS at the time of discharge who were selected randomly. A total of 500 patient were studied.

Study design.

It was a cross sectional study in prospective design which was carried out for a period of six months from 1"Jan 2006 to 1" July 2006.

Observations.

Assessment of the data revealed(Table -A) that 63% of those interviewed for the survey were females and maximum of the respondents belonged to middle socio economic status (income Rupees 5000 10000 per month).There was also a preponderance of rural patients (65%) who had gone through the instrument of questionnaire. Analysis of the data further revealed that among 500 patients surveyed 95% (n=475) were provided diet by the hospital dietetics department. Categorization of diet into various types revealed that 83% had received full diet, 13% soft diet and 4% therapeutic diet. Maximum (75%) of patients revealed that they had been enquired about the choice of diet by the hospital staff.

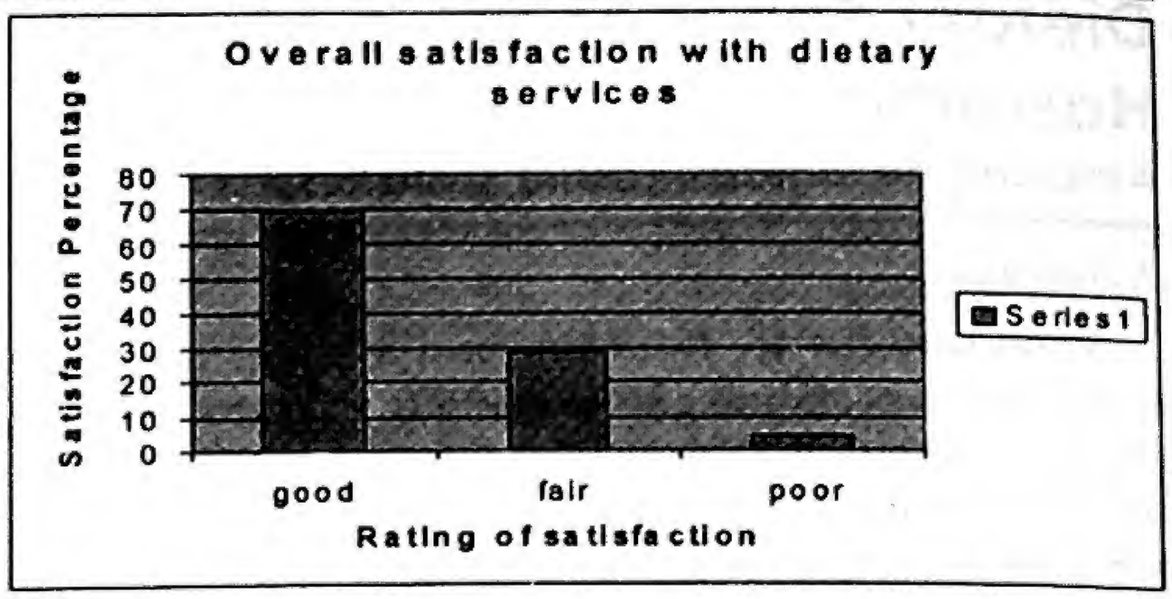
Aspects of food served	Good	Fair	Poor
Appearance and Aroma	68 %	37%	5%
Cleanliness of food servings and trays	74%	22%	4%
Temperature of food served	70%	29%	1%
Variety of food served	73%	24%	3%
Portion sizes of food served	68%	32%	10%
Flavor of food served	66%	32%	2%
Completeness of meals	70%	26%	4%

Table A: Percentage satisfaction with various aspects of food services.

Important aspect of diet which was surveyed revealed that 68% rated appearance and aroma of the food served as "Good" while only a small percentage 5% rated it as poor. Among percentage of dissatisfiers most 80% of them had received either liquid or therapeutic diet.

Temperature of the food served plays a vital role in the client satisfaction. Our study revealed that 70% of the users rated temperature of the food served as good while 29% rated it as fair. 73% of the patients were satisfied with the variety of food served. Portion size of the food served indicated that 68% of those served rated portion as good while 10% rated as poor. Clients acceptance of flavor of the food served revealed that 76% were satisfied and rated it as good only 4% of the users rated completeness of food served as poor.

Dietary advice was given to only 57% of the patients by the hospital staff at the time of discharge.



Overall satisfaction with various dietary aspects studied revealed that 69.85% rated dietary services at SKIMS as Good 28.8% as Fair and only 4.14% as poor.

The effect of patient demographic characteristics on satisfaction with various aspects of food services studied did not reveal any significant difference.

Discussion

Patient satisfaction is an important measure of service quality in health care systems. Patient perception about healthcare system seems to have been largely ignored by the healthcare managers in developing countries. The aim of our study was to develop a reliable measure of satisfaction of consumers of food services in hospitals.

Observations of the study revealed that 95% of the patients surveyed had their nutritional requirements fulfilled by the hospital dietetics services. Stephen etal reports that 80 -100% patients in hospitals and institutions depend solely on the food provided for their nutritional support.[3]

Food flavour is a combination of sensations and is perceived differently by each person. Taste, aroma and feel of foods play a large part in determining whether an individual thinks a food has good flavour. Temperature is another aspect of food that strongly influences flavour perception. Observation of the study revealed that 68% of patients rated appearance and aroma of the food served as good and 73% were satisfied with the variety of the food served. Deluco etal in their study found that greater than 65% of the respondents indicated that hospital food was of "Good" quality for characteristics of taste, aroma, appearance, tenderness, temperature, freshness and nutrients value.[4] Stanga. Z etal in their study concluded that 86% of respondents were satisfied with the hospital foods. Patients felt that the temperature, appearance and aroma of the foods were particularly important.[5] Sahin B.etal showed that variables of taste and appearance of food were statistically important determinants of patients satisfaction with the food served at hospital.[6]

This study revealed that 68% of those served rated portion sizes (quantity) as "Good". Ohara P.A. etal in

Patient Satisfaction in Outpatients Department of a Teaching Hospital

R A Rengrez (Shah); Tabish S A; Shoukat H Khan; I A Bukari; Samina Mufti.

Abstract

Patient satisfaction surveys are increasingly used as an outcome measure in various health care settings. The popularly that outpatient services are gaining in hospital settings make pertinent the conduct of such surveys in outpatient departments, in the quest for quality improvements. Aim of the study is to elicit patient satisfaction with care factors in the outpatient department of a tertiary care hospital. A prospective, descriptive survey was conducted with a sample of 200 patients who were put to a questionnaire while preparing to leave the department. Patient satisfaction was elicited with some prime care factors including waiting times, behaviours of the doctors and paramedics and convenience of public utilities. They revealed that patients are satisfied with the services, save waiting time at registration counters. Prolonged registration time needs some reengineering in the form of more medical record technicians, introduction of advance and individual appointment system, together with extended clinic timings.

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Introduction

Outpatient department has been described as hospitals showcase or shop window, as it is the point of first contact between hospital and the community (1). As outpatient department of a hospital is an establishment, which cares for the ambulatory patients, who come for diagnosis, treatment and follow-up, so it is also the image building area reflecting the quality of care being provided.

Properly planned and technologically advanced outpatient department incorporating new patient care conceptions of extended ambulatory services and cost effective techniques provide a fairly pleasant impression on the users of the services.

20 to 30% patients admitted to hospitals do not require full professional care normally received by acutely ill patients (2).This large group of patients can satisfactorily be treated in outpatient department, provided basic management tools of care like capabilities, criteria, commitment, clout, creativity and choice, are taken care of. Personalized care rendered by the doctors, nurses and paramedicals together with waiting time form the care factors that drive patient satisfaction (3). Patient satisfaction studies will throw light on the functioning of existing system in the context of degree of utilization of outpatient services of Sher-I-Kashmir Institute of Medical Sciences, which is a 600 bedded tertiary care teaching hospital with a state of art technology and expertise. This hospital is providing quality patient care besides Medical Education and need based biomedical research.

Methodology

Study was conducted during 1997-1999. Two hundred patients were subjected to a questionnaire. Patients were interviewed while preparing to leave the department to eliminate any bias. No patient was subjected to a questionnaire while busy at any operative or functional service counter, laboratory or consultation room.

Various responses of care factors used in questionnaire were categorized in an arbitrary manner as :

Key words: *outpatient, care factors, waiting time, utility service.*

and medical record technician's behavour and the same is also true in our study.[4]

As patients seem to be concerned with time factor, particularly at registration counter,this can be addressed by having more medical record technicians, introducing advanceand individual appointment system, together with extending the timings of regular clinics as patient response is better as compared to the evening clinics because better support service back-up is available.

Although study reveals , patients are by and large satisfied with the services, but there is still a scope for improvement and that too without indulging in capital intensive exercises. By involving cheaper but pragmatic options, a quality care can be ensured.

CONCLUSION

The study reveals that majority of patients had highest degree of satisfaction, regarding the services save registration timings

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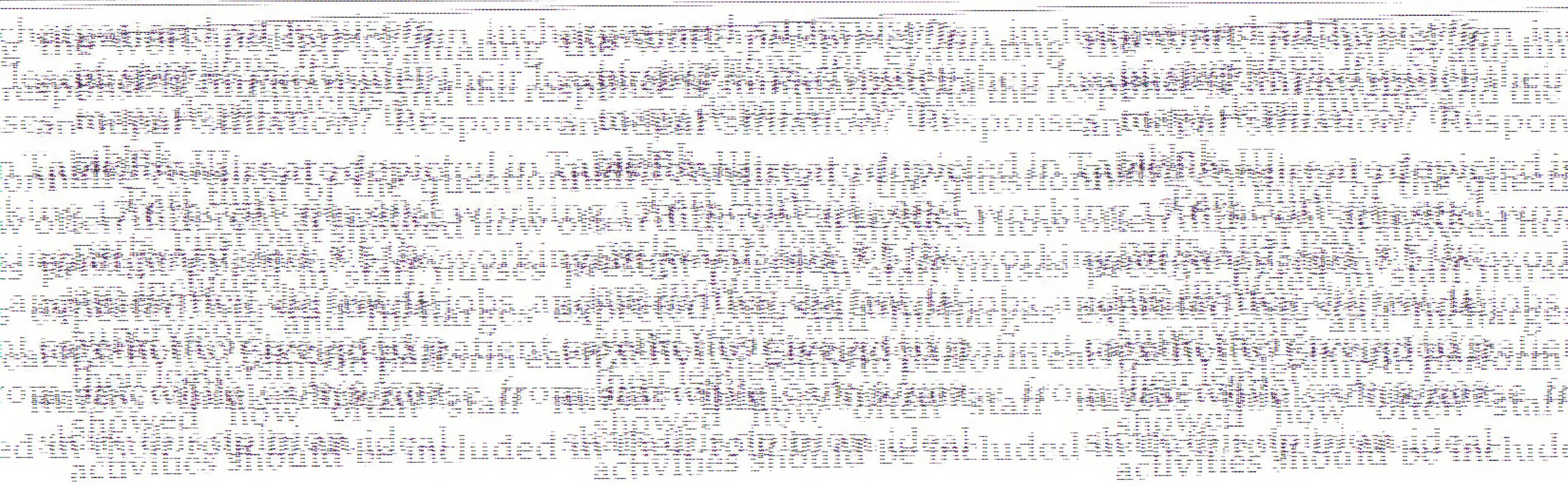
Impact of Urgent Interventions on Perceptions of Overcrowding in the Emergency Department

Ingrid Ranger BA, Pamela Kelly BA, Carol Ann Gallagher BA, Pamela Kelly BA, Carol Ann Gallagher BA, Pamela Kelly BA, Carol Ann Gallagher

Abstract Abstract Abstract

CJEM Supplement 2007;9(Supplement 2):S28-S32 CJEM Supplement 2007;9(Supplement 2):S28-S32 CJEM Supplement 2007;9(Supplement 2):S28-S32

Introduction Introduction Introduction



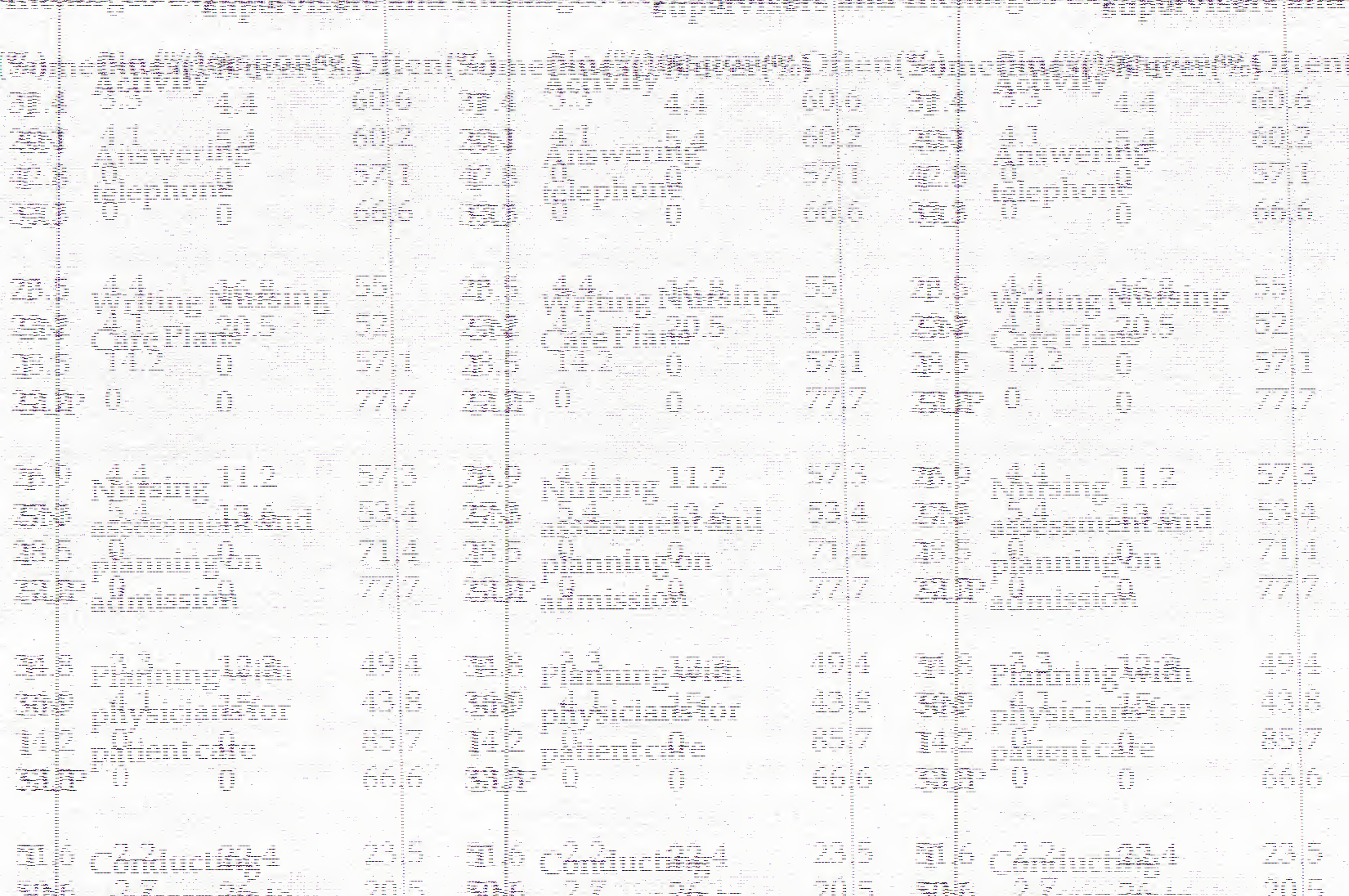


TABLE-III: showing how often staff nurses think different activities should be included in their role in an ideal situation and how often incharges and supervisors expect nurses under their leadership to perform in an ideal situation

Activity		Never(%)	Sometimes(%)	Often(%)	No (%)response
	T	8.9	41.5	48.3	1.1
Answering	SN	9.5	43.8	45.2	1.3
telephone	I	0	28.5	71.4	0
	SU	11.1	33.3	55.5	0
Writing Nursing	T	5.6	24.7	66.2	3.3
Care Plans	SN	6.8	20.5	69.8	2.7
	I	0	71.4	14.2	14.2
	SUP	0	22.2	77.7	0
Nursing	T	8.9	29.2	57.3	4.4
assessment and	SN	10.9	28.7	54.7	5.4
planning on	I	0	57.1	42.8	0
admission	SUP	0	11.1	88.8	0
Planning with	T	1.1	34.8	53.9	5.6
physicians for	SN	1.3	35.6	52	5.4
patient care	I	0	42.8	42.8	14.2
	SUP	0	22.2	7.77	0
Conducting	T	3.3	47.1	34.8	8.9
conferences to	SN	2.7	50.6	32.8	5.4
plan nursing care	I	14.2	42.8	42.8	14.2
	SUP	0	22.8	44.4	33.3
Talking with	T	11.2	16.8	64	7.8
patients about	SN	10.9	17.8	61.6	9.5
their concerns	I	28.5	14.2	57.1	0
	SUP	0	11.1	88.8	0
Keeping records	T	1.1	13.4	78.6	6.7
in order	SN	1.3	15	76.7	6.8
	I	0	14.2	71.4	14.2
	SUP	0	0	100	0
Giving	T	6.7	14.6	76.4	2.7
instructions to	SN	6.8	13.6	76.7	2.0
patients about	I	14.2	14.2	71.14	0
their role in their care	SUP	0	22.2	77.7	0

T=Total No., SN=Staff Nurse, I=Ward Incharges, SUP=Supervisors

56.9% nurses who are trained from SKIMS advocate planning with physicians while as only 44.4% and 37.5% of nurses who are trained in SMHS and outside state advocate this activity. 75% of nursing staff who had training from outside state advocate writing nursing care plans while as only 66.6 from SMHS and 65.2 from SKIMS hold this opinion. 77.7% of nurses who had training from SMHS advocate nursing assessment and planning on admission while as only 55.5 and 50% from SKIMS and outside state have this opinion. 88.8% of nursing staff who had training from SMHS advocate talking with patients about their care while as only 62.5 and 61.1 % from outside state and SKIMS advocate this activity. 77.7% of nurses with training from skims advocate keeping records in order while as only 66.6%and 62.5% from SMHS and outside state advocate this activity.

Regarding frequency of possible descriptions of the behavior of immediate superiors at different positions ; 60.6% of nurses believe that superiors size up situation quickly and accurately . 57.2% of nurses

while as only 44.4% and 37.5% of nurses who are trained in SMHS and outside state advocate this activity. Nurses need to be more frequently involved in planning with physicians for patient care and should be an integral component of patient care.[8] Holding conferences to plan nursing care does not seem to be a frequent feature at SKIMS. The nurses with training from different colleges have different strengths and weakness. Hospital administrators should give orientation to nurses at the time of their joining . Nurses should know what is expected of them and frequent performance appraisals including self appraisals need to be conducted. 51.6% of nurses conduct conferences but in an ideal situation majority advocate this activity to be done only sometimes. 60.6% of nurses talk with patients about their concern while as in ideal situation 64% of nurses advocate this activity. Percentage is higher among supervisors and incharges, 77.7% and 71.4% respectively than staff nurses 37.5%. Percentage of supervisors who advocate it in an ideal situation is higher 88.8%. Higher percentage of nurses who have obtained training from SMHS, 88.8% advocate talking with patients about their care. Studies have shown that nurses consistently underestimated the extent to which patients valued most aspects of good nursing care and that talking with patients would give nurses insight into the patient's expectations of care.[7] 80.8% of nurses in present position and 78.6% in an ideal situation want records to be kept in order. Higher percentage of nurses who had training from SKIMS Nursing College than those who had training from SMHS and outside advocate keeping records in order. One of the studies has recommended simplifying nursing documents so that thing could be kept in order in least possible time.[1] 67.4% of nurses give instructions to patients about their role in care and 76.4% advocate it in an ideal situation. Higher percentage of nurses who had training from SKIMS Nursing College advocate this activity to be done often.

Responses to part IV of the questionnaire showed that staff was fairly satisfied with superiors except some deficiencies like supervisors back down when they ought to stand firm, lets some staff members take advantage of her, and is reluctant to give them any freedom of action. Supervisors should maintain the moral of staff as frustrated and demoralized nurses give rise to concern for hospital nursing management in providing quality care according to set standards.[1]

Responses to part-V of the questionnaire showed that adequacy of nursing staff needs to be looked into as significant proportion of nursing staff is overburdened. Organizational aspects of nursing at skims should be studied in detail and steps taken to bring in accountability and sense of responsibility. Supervisors should get more involved in work. In other studies, the main factor identified by nurses as influencing service provision related to organizational issues such as inadequate staffing levels,[9] limited resources, excessive work demands, down sizing, unfairness, biased nursing management, stress associated with high workload.[1,9,10] Other dissatisfiers identified were lack of appreciation and monitory incentives.[1] Number one dissatisfier in our study was the promotion avenue 93% while 48.3% of nursing staff was not satisfied with their immediate supervisors. This again raises number of questions on organizational structure of nursing department as on one hand nurses are not satisfied with promotion avenues and on one the other hand majority were of the opinion that number of supervisors was far greater than required. One of the studies on perception of quality among hospital staff in teaching hospitals of Kashmir Division showed that nursing personnel rated lowest in all hospitals on quality aspects of health care delivery although nurses of SKIMS had positive perception which was slightly higher than in the other hospital.[11]

Conclusion

In order to provide quality health care special attention needs to be given to organizational issues such as role clarity, clear work assignments of people from different departments and well established routines. Nurses need to be more frequently involved in planning with physicians for patient care and nurses management groups need to be empowered. More percentage of nurses time needs to be devoted towards actual patient care and activities like answering the telephone, bed making should be the job of less qualified staff like nursing aides. Nursing documentation should be simplified. Control in the work environment is an important factor in maintaining a quality work place but over-stressed and frustrated nursing staff can be a concern for providing quality care. Nursing supervisors should be using motivational techniques to get most out of their staff. CME's should be a regular feature. Further research is recommended on career development of nurses and its problems.

Utilization Of Intensive Care Units In A Tertiary Care Hospital

Deva Shafa, Mutaharra H.A, Bukhari I.A, Naqishbandi J.I, Samiya Mufti

Abstract

Intensive care units are the most expensive, high technology and resource intensive areas of medical care working all the year round. A study was conducted on the workload of these units in SKIMS-a tertiary care hospital in J&K. A retrospective study was conducted for one year from Jan.2001 to Dec.2001 to find the workload. It was found that Bed occupancy of these units as 98.5% and Turnover interval at negative value suggesting non-availability of beds at certain crucial moments. The Average length of stay was 5 & 4 days for Intensive cardiac care & Surgical intensive care units.

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Introduction

Intensive care unit is a specialised facility that provides intensive care medicine. Of the total acute hospital costs, 20% is the cost of intensive care.[1] **Intensive care** is management of the ongoing physiological abnormalities observed in a critically ill patient using higher processing and integrating skills. Most large hospitals will need only 2 to 6 percent of the total hospital beds for intensive care treatment. This may vary, depending whether the unit is centralized for the hospital or associated with a particular department. Keeping in view the overall viability of intensive care units, eight to twelve beds per unit has been found to be ideal, from the functional perspective. However margin of having more beds(more than 5% of total hospital bed complement) for a centralized type of intensive care unit has to be kept in mind. This study to ascertain the workload of intensive care units at SKIMS was conducted with the aim of analysing and justifying the number of beds allotted to intensive cardiac care and surgical intensive care units and to find out the utilization of this costly facility.

Material & Methods;

The study was conducted in two Intensive care units(for adults) of Sher-i-Kashmir Institute of Medical Sciences, Srinagar. After obtaining permission and getting formally introduced to the staff of these units, the subject was discussed with doctors, nursing staff, technicians and skilled and unskilled functionaries of wards. The pretesting and standardizing of the proforma was undertaken in a pilot study of two weeks before actual study. The study was conducted as;

Retrospective study for one year from Jan. 2001 -Dec.2001 by studying records of all inpatient case sheets for the year.

The study population were all the patients in the intensive care units and entry or exit of patient into or out of intensive care unit was considered as admission into or discharge from the concerned unit. All inpatient case sheets were studied using pretested proformae. The ward medical register was also used for patient records. Average length of stay of each patient was calculated from date of admission to discharge. Average daily census was obtained from medical records data for SICU while for cardiac care unit proformae were used.

Following formulae were used;

Keywords: Intensive care units, Surgical intensive care units, Intensive cardiac care units, Bed turnover rate, Bed occupancy rate, Average length of stay.

suggest that bed occupancy in surgical intensive care unit should be kept around 70% leaving rest of the beds always available for emergencies. Another available data suggests an optimal intensive care unit occupancy of 70-80% as ideal[4]. Bed occupancy rate of more than 85% has been found to be associated with increased incidence of Methicillin resistant staphylococcus aureus infection[5].

There are many reasons for the high bed occupancy rate in intensive care units of Sheri Kashmir Institute of Medical Sciences, like-excessive trauma patient admission, post-operative care to CVTS and neurosurgical patients, organo-phosphorus poisoning case management, cardiac ailment burden in community, pulmonary complications and problems in higher age group with their slow convalescence and non availability of ICU facilities in other hospitals of the valley.

Due to this high bed occupancy in the ICU'S, the turn-over rate of beds is 5 in Cardiac intensive care unit while it is 8 in Surgical intensive care unit, which indicates over utilization of intensive care beds.

Observations revealed that average length of stay was variable in two intensive care areas. ALS in Cardiac intensive care unit varied around a mean of 5 days while in SICU, the rate was 4 days. It was observed that ALS had large swings due to admission of organo- phosphorus poisoning cases to SICU and stay of these patients for a long time in these units. In Cardiac intensive care unit, the aging population with their slow convalescence shifted the overall average length of stay of patients. It is being recommended that ALS be kept as short as possible but it is quite different at different centres varying between 2-12 days in U.K,4-5 days in Germany and 4.1 days in Finland[3]. Average length of stay is being recommended to be kept around 5-6 days for efficient utilization of intensive care unit. The present study is nearer to European averages.

The study reveals that ICU beds are over utilized and a number of critically ill patients do not get benefit of this facility. Though various researchers have suggested 20-30% beds should always be made available for acutely ill patients. So, aim should be to reduce bed occupancy rate by following strict admission\discharge protocols and to add more beds in the area.

Foot-note; In SICCU of SKIMS four beds have been added in June,07 along with state of art infrastructural inputs.

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Perceptions of Indian immigrants in Singapore about their experiences of living with type 2 diabetes: A qualitative study

Dr. Bhatia Deva

Abstract

Aim: To explore the perceptions of Indian immigrants in Singapore about their experiences of living with type 2 diabetes.

Methods: Semi-structured interviews were conducted with 20 participants aged 40 years and above-elderly.

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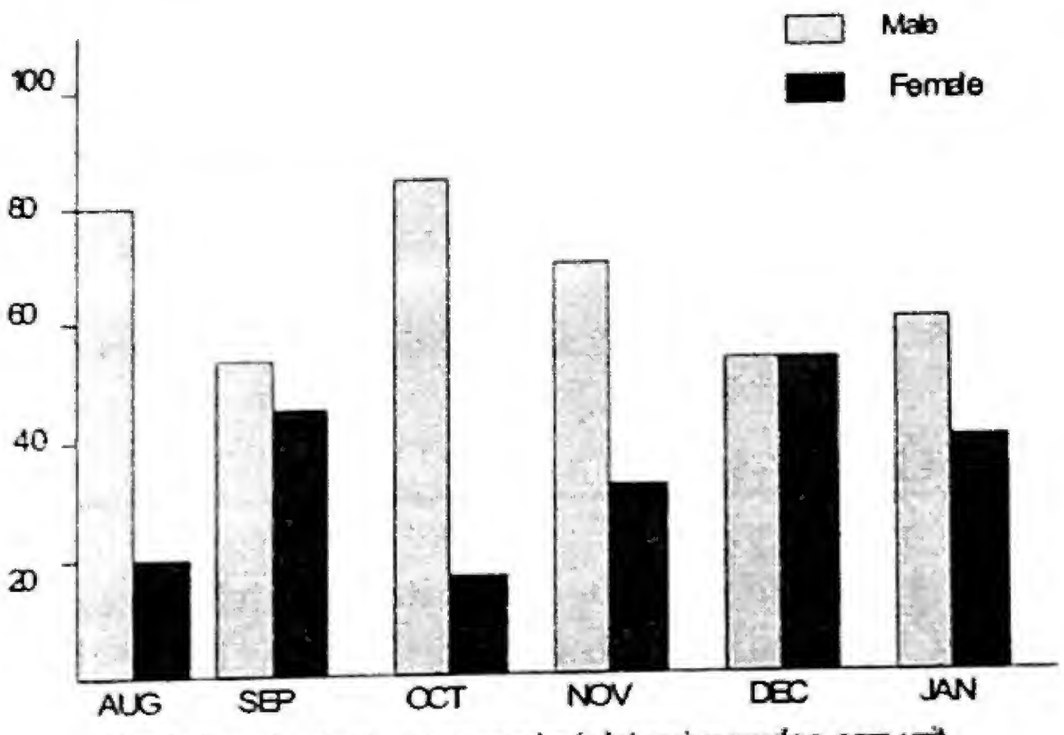
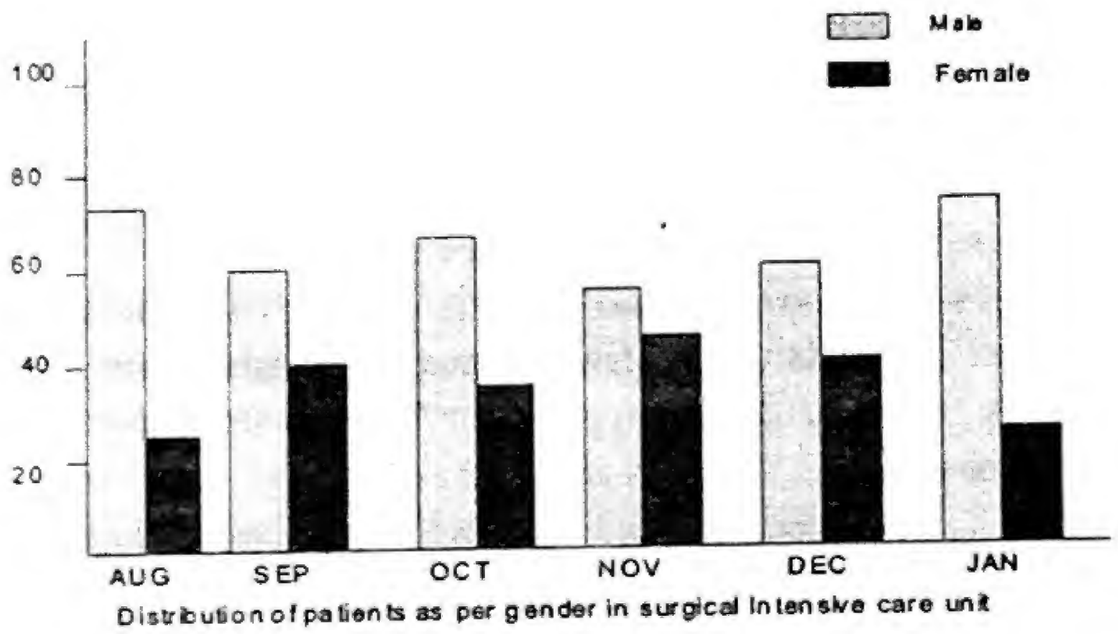


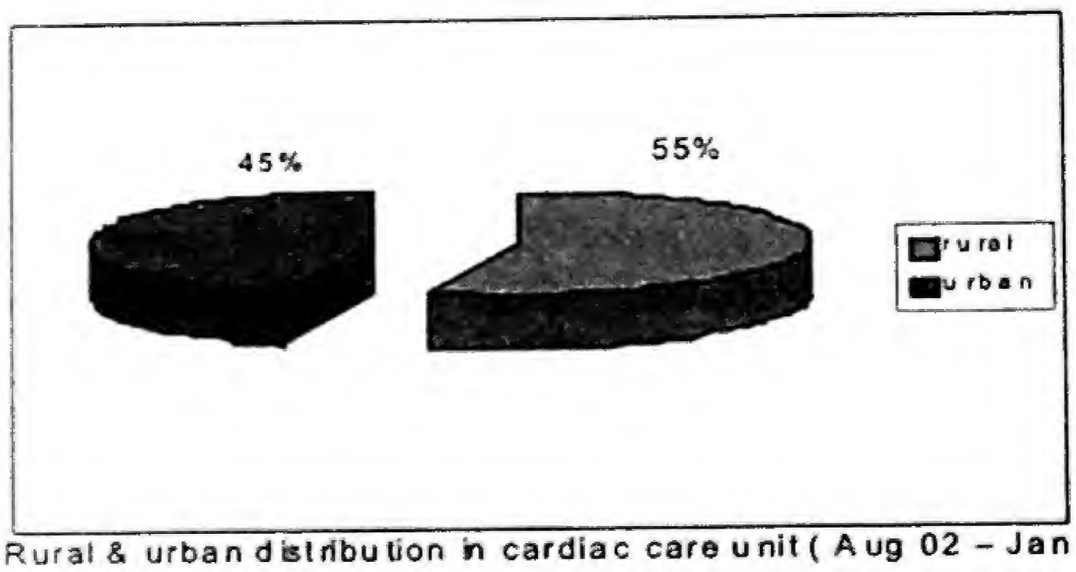
Distribution of patients as per gender in Intensive cardiac care unit



Distribution of patients as per gender in surgical Intensive care unit

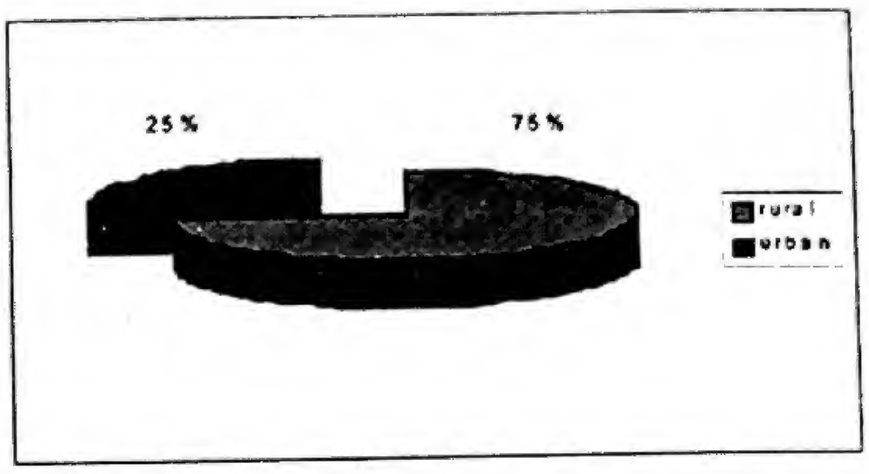
90% patients in the two units were in acute stage of disease.80% smokers and 20% non-smokers were admitted in ICCU and 55% smokers and 45% non-smokers were admitted in SICU.

45% literates used the services as compared to 55% illerates for both SICU and ICCU.



Rural & urban distribution in cardiac care unit (Aug 02 – Jan 03)

Patients with average socio-economic status(Prasad's scale)mostly (88%) used the intensive care services i:e SICU& ICCU.Rural\Urban distribution for ICCU was 45% and 55% for SICU it was 52% and48%.



Rural & Urban distribution distribution in Surgical intensive care unit (Aug 02 – Jan 03)

DISCUSSION

Profile of patients has a definite impact on intensive care services of the hospital, as is evident from the study.Mostly young adults(26-45yrs) with a predominance of males, are admitted in intensive care units[3]. This may be because of the fact, that this productive age group is most vulnerable to environmental hazards. Male smokers in large number(80% in ICCU) have been admitted during study period. This points to direct relation of smoking to cardiac ailments in this group.

More than 90% of patients have acute illness at the time of admission, which justifies the nature of the services and 10% of patients who were not in acute stage of illness[2], could have been treated in a non-intensive care area like wards etc.

The services are used mostly by the urbanites. This may be because of the fact that care area is in within the reach as compared to rural population in which case a good number of patients do not reach the hospital or expire before the treatment is provided.

Study reveals that middle income group mostly(88%) use the services and have full faith in the hospital, as SKIMS is the only tertiary care centre in the valley.

However the intensive care units of SKIMS have a scope for further expansion in terms of manpower and physical infrastructure, so as to cater to needs of general public, where demographic, social and economic profile constantly change.

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Impact of Preoperative Nutritional Status on Postoperative Outcomes in Patients Undergoing Major Abdominal Surgery: A Prospective Study

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Abstract

Background: Malnutrition is a common but often overlooked problem in patients undergoing major abdominal surgery. It can delay recovery, increase infection rates, and prolong hospital stay. This study aimed to assess the impact of preoperative nutritional status on postoperative outcomes.

Methods: A prospective observational study was conducted on 200 patients undergoing elective major abdominal surgery. Nutritional status was assessed using standardized tools before surgery. Patients were followed for postoperative complications, length of stay, and mortality.

Results: Malnourished patients had significantly higher rates of infectious complications and longer hospital stays compared to well-nourished patients. Mortality was also higher in the malnourished group.

Conclusion: Preoperative nutritional assessment and timely intervention can improve surgical outcomes. Routine screening should be integrated into surgical care pathways.

Introduction

Major abdominal surgery is associated with significant physiological stress and metabolic demand. Patients who are already malnourished before surgery are at increased risk of postoperative complications, including wound infections, anastomotic leaks, and prolonged ileus. Despite this well-established relationship, preoperative nutritional assessment is not routinely performed in many surgical services.

Early identification of malnutrition allows for timely intervention, such as dietary counseling, oral nutritional supplements, or enteral feeding, which can improve outcomes. However, there is limited data from our region on the prevalence of malnutrition and its impact on surgical outcomes.

This study was undertaken to evaluate the nutritional status of patients undergoing major abdominal surgery and to determine its association with postoperative complications and mortality.

Methodology

A prospective observational study was conducted in the Department of General Surgery, SKIMS, Soura, Srinagar, over a period of 12 months. Patients aged 18 years and above undergoing elective major abdominal surgery were included. Patients with emergency surgery, malignancy, or those who refused consent were excluded.

Nutritional status was assessed using the Subjective Global Assessment (SGA) and the Nutritional Risk Index (NRI). Patients were classified as well-nourished, moderately malnourished, or severely malnourished.

Postoperative complications were recorded up to 30 days after surgery. Data were analyzed using SPSS version 25. Chi-square test and Fisher's exact test were used for categorical variables, and Student's t-test for continuous variables. A p-value less than 0.05 was considered statistically significant.

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Discussion

Discussion
Discussion

Thoracic surgery in Small Animal Practice: Intercostal Thoracotomy

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Thoracic Surgery Treatment

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